

MEDICAL CARE

FOR THE PEOPLE

of

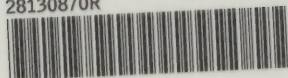
NEW YORK STATE

**Report of the New York State Legislative
Commission on Medical Care**

FEBRUARY 15, 1946

W 275 AN6 qC7m 1946

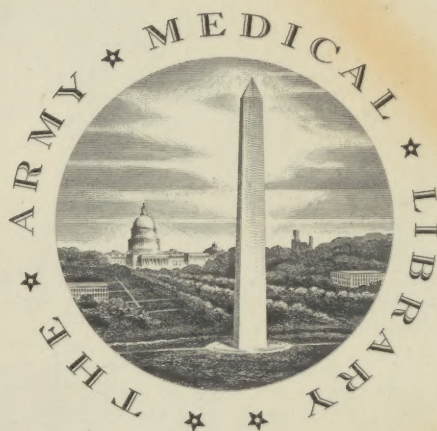
28130870R



NLM 05114703 4

NATIONAL LIBRARY OF MEDICINE

UNITED STATES OF AMERICA



FOUNDED 1836

WASHINGTON, D.C.

Medical Care for the People of N. Y. State

Name

Out

In

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE

OFFICIAL BUSINESS

MEDICAL CARE

FOR THE PEOPLE

of

NEW YORK STATE

Report of the New York State Legislative

New York (State) **Commission on Medical Care**

'''

Established Pursuant to Chapter 387 of the Laws of 1944

and Chapter 5 of the Laws of 1945.

FEBRUARY 15, 1946

MEDICAL CARE

FOR THE PEOPLE

W

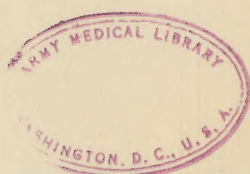
275

ANG

9C7m

1946

.C11



6-1-14-53

LETTER OF TRANSMITTAL

To His Excellency, the Governor of the State of New York, and to the Honorable Members of the Legislature of the State of New York:

The Commission on Medical Care has the honor to submit herewith its report on the existing pattern of medical care and medical insurance in New York State. Proposals for methods of attaining the objectives prescribed for the Commission have not been the subject of unanimous agreement and for this reason the recommendations of the dissenting members as well as the recommendations of the majority are commended to your attention.

Respectfully submitted,

Basil C. MacLean, M. D., Chairman

Lee B. Mailler, Vice-Chairman,
Assemblyman

Marion W. Sheahan, R. N., Secretary

Msgr. John J. Bingham

Harold R. Brown, M. D.

Lucien Brown, M. D.

James A. Corcoran,
Senator

Andrew A. Eggston, M. D.

Leonard Farbstein,
Assemblyman

Agnes Gelinas, R. N.

Edward S. Godfrey, Jr., M. D.,
State Commissioner
of Health

Ruth Hall, R. N.

Frederic E. Hammer,
Senator

Robert T. Lansdale,
State Commissioner
of Social Welfare

Robert L. Levy, M. D.

Frederick MacCurdy, M. D.
State Commissioner
of Mental Hygiene

George M. MacKenzie, M. D.

Herman G. Weiskotten, M. D.
Garrard Winston

February 15, 1946

Paul A. Lembcke, M. D., M. P. H.
Director of Study

Responsibility for Report

With the exception of recommendations, which are the responsibility of the subscribing members, and the survey of public opinion which was conducted by and is reported for the Commission by Surveys Incorporated, the report of the Commission was prepared by the Director of Study largely from material which had been made available to the Commission members for study and discussion as it was acquired. Except as noted above, the report as presented has been accepted by the Commission as a whole, although the Commission assumes no responsibility for the detailed data, interpretations, comments or opinions.

INTRODUCTION

The subjects of medical care and medical insurance are among the foremost of the domestic issues of the day. Although a majority of the members of the Commission on Medical Care did not recommend immediate and positive action by the Legislature, the subject remains a live one in New York State and is under active discussion by many interested groups, official and non-official. A limited number of mimeographed copies have been prepared for distribution to members of the Legislature prior to the close of its session, and to meet the many requests which have been made by persons and groups who have been associated with or vitally interested in the Commission activities, for the complete text of the report at an early date. Printed reports will be available some months hence.

Public demand for a better system of financing medical care has brought us to the point where this subject can no longer be dealt with solely in terms of general principles. Possible solutions in the form of legislative proposals have not warranted or received proper consideration because they have not been substantiated by facts. The studies made by the Director of Study, which have been along lines indicated by the Commission as a whole, in my opinion fill a long-felt need and constitute an outstanding contribution to the subject of medical economics. Although they apply to New York State only, they set a pattern to be followed in other State and Federal studies. In no other instance of which I am aware have the many aspects of this varied problem been probed so deeply and the possible solutions reduced to such concrete terms. The excellence of the well-rounded report and the penetrating analyses made by the Director of Study reflect a competence and objectivity which have not flagged in the face of circumstances which have often been discouraging. It could not be expected that the Commission as a whole would be in a position to scrutinize and act on every phase of a report covering such a large field, nor that nineteen persons with different backgrounds and interests would be in agreement on every point if they did. The interpretative or analytical comments are sufficiently distinct from the facts to permit the reader to make his own appraisal.

The task of the Commission and its study staff has been made doubly difficult by the fact that the Commission assumed the responsibility of determining not only the form in which good medical care should be made more available to the people, but also whether the State should take any

action in this field. To the extent that the Chairman has been responsible for direction of the Commission's activities, there has never been any thought that the members of the Commission would or should act other than as citizens performing a public duty in response to the needs of the people as a whole. The duties of the office were approached with an open mind, without pre-formed conclusions, and without commitment to anyone. Any departure from this viewpoint which may have occurred on the part of any member has been beyond the control of the Chairman and, it is believed, the Commission as originally constituted.

Basil C. MacLean, M. D.

TABLE OF CONTENTS

TITLE PAGE	
INTRODUCTION	
LETTER OF TRANSMITTAL	1
RESPONSIBILITY FOR REPORTS	11

PART 1

REPORTS AND RECOMMENDATIONS OF COMMISSION MEMBERS

MAJORITY REPORT (Nine Members)	1
MINORITY REPORTS	3
Minority Report No. 1 (Five Members)	4
Minority Report No. 2 (Two Members)	9
Minority Report No. 3 (One Member)	20
Minority Report No. 4 (One Member)	22
CHAIRMAN'S SUPPLEMENTARY REPORT	24
Measurement of Attitudes of New York State	
Public Opinion Toward Certain Specific	
Plans for Doctor and Hospital Insurance	26

PART 2

MEDICAL CARE AND MEDICAL INSURANCE

STUDIES CONDUCTED FOR THE COMMISSION BY THE DIRECTOR OF STUDY

INTRODUCTION

CHAPTER I. THE COMMISSION ON MEDICAL CARE

Creation of the Commission and Definition of Its	
Scope	42
Membership of the Commission	43
Relationship to State Health Preparedness Commission	45
Relationship to Other State Agencies	46
Objectives	46
Methods of Study	48

CHAPTER II. THE NEED FOR MEDICAL CARE

Health Trends	49
Reasons Underlying Increasing Need for Medical Care.....	50
Current Health Status of the People	53

CHAPTER III. THE ECONOMIC ASPECTS OF MEDICAL CARE

Purpose and Scope of Study	58
Prevalence and Incidence of Illness	60
Receipt of Medical Services	65
Expenditures for Medical Services	66
Individual and Group Methods of Paying for Medical	
Care	72

CHAPTER IV. THE PATTERN OF MEDICAL CARE IN NEW YORK STATE	
Types of Service or Programs	84
Cost of Services or Programs	88
CHAPTER V. PUBLIC MEDICAL CARE	
(MATERNAL AND CHILD HEALTH SUPERVISION, EMERGENCY MATERNITY AND INFANT CARE PROGRAM, DENTAL SERVICE FOR PRESCHOOL CHILDREN, SCHOOL HEALTH SERVICE, PHYSICALLY HANDICAPPED CHILDREN, PUBLIC HEALTH NURSING AND LABORATORIES)	
Definition and Scope	94
Maternal and Child Health Supervision	94
Emergency Maternity and Infant Care Program	101
Dental Service for Pre-School Children	103
School Health Service	104
Physically Handicapped Children; Adult Poliomyelitis	
Cases	109
Vocational Rehabilitation	115
Public Health Nursing	120
Laboratory Service	126
CHAPTER VI. PUBLIC MEDICAL CARE, CONTINUED	
(TUBERCULOSIS, VENEREAL DISEASE, CANCER, MENTAL HOSPITALS)	
Tuberculosis	136
Venereal Disease	144
Cancer	148
Mental Hospital Care	153
CHAPTER VII. PUBLIC MEDICAL CARE, CONTINUED	
(VETERANS, PUBLIC GENERAL HOSPITALS AND PUBLIC WELFARE MEDICAL PROGRAMS)	
Veterans	158
Public General Hospitals	160
Public Welfare Medical Programs	170
Local Expenditures for General Medical Care	183
CHAPTER VIII. PUBLIC MEDICAL CARE, CONTINUED	
(WORKMEN'S COMPENSATION AND MISCELLANEOUS PROGRAMS)	
Workmen's Compensation	185
Miscellaneous Programs	198
CHAPTER IX. THE COST OF MEDICAL CARE	
Physicians' Services	200
Dentists' Services	202
Nursing Service	204
Hospital Service	204
Other Services	205
CHAPTER X. PRIVATE MEDICAL AND HOSPITALIZATION INSURANCE	
Group Health and Accident Policies	206
Individual Policies	207
Comparison of Private and Non-Profit Policies	207
CHAPTER XI. NON-PROFIT HOSPITAL SERVICE PLANS	
History and Development	209
Legal Status	210
General Characteristics	212
Coverage	213
Growth in Coverage	216

Eligibility for Coverage	218
Comparison of Blue Cross Subscribers with General Population	219
Cost of Insurance	224
Benefits Provided	227
Ward Service	231
Utilization of Hospital Facilities	233
Summary	233
CHAPTER XII. NON-PROFIT MEDICAL CARE INSURANCE	
Types of Medical Insurance	235
Legal Aspects	239
General Characteristics	240
Income and Expenditures	245
Eligibility and Benefits	247
Group Health Cooperative	247
United Medical Service	251
Health Insurance Plan of Greater New York	254
Western New York Medical Care Plan	255
Central New York Medical Care Plan	257
Genesee Valley Medical Care Plan	258
Summary	260
CHAPTER XIII. FACILITIES FOR MEDICAL CARE	
Physicians	262
Dentists	275
Optometrists	278
Nurses, except Visiting Nurses	279
Visiting Nurses	283
CHAPTER XIV. FACILITIES FOR MEDICAL CARE, CONTINUED (GENERAL HOSPITAL AND CLINIC FACILITIES)	
Volume of Service Required	290
Volume of Service Provided	290
Existing Facilities and Utilization	293
Federal Aid for Hospital Construction	305
Licensure and Supervision	309
Clinics and Dispensaries	314
CHAPTER XV. STATE AND NATIONAL MEDICAL INSURANCE	
Summary of Features of Existing National Plans	322
Great Britain	322
New Zealand	329
Proposed State and National Plans (Arkansas, Rhode Island, Massachusetts, California, New York (Ives Bill), New York (Austin, Jack, Joseph Bills), United States (Wagner-Murray-Dingell Bill).....	338
CHAPTER XVI. MEDICAL CARE PLANS CONSIDERED BY COMMISSION	
More Adequate Care for Low-Income Non-Relief Groups	352
Medical Insurance for Certain Groups of Relief Recipients	353
State Aid for Diagnostic and Health Centers in New York State	355
Medical Insurance Plans In General	357
Guiding Principles for a Medical Insurance Program	361
Summary of Features of Plans Studied	366

CHAPTER XVII. CONFERENCES ON MEDICAL INSURANCE WITH REPRESENTATIVE GROUPS

Plans Discussed	369
Conduct of Conferences	373
New York State Conference of Hospital Service Plans	375
New York State Federation of Labor.....	376
International Ladies Garment Workers Union	376
Medical Society of the State of New York	377
Private Medical Care Plans	379
New York Academy of Medicine	380
Hospital Association of New York State and Greater New York Hospital Association	381
New York State Dental Society	382
New York State Nurses Association	383
New York State Council of Retail Merchants	385
Associated Industries of New York State	385
Commerce and Industry Association of New York	386
State Charities Aid Association	387
New York State Grange	388
Life Insurance Association of America	389
Health and Accident Underwriters Conference	391
Bureau of Personal Health and Accident Underwriters	391
Association of Casualty and Surety Executives	392
New York State Industrial Council, CIO	393
Other Groups	395

CHAPTER XVIII. PUBLIC OPINION ON MEDICAL INSURANCE

"What Do the American People Think About Federal Health Insurance"	399
"Public Relations of the California Medical Profession" ...	400
"Public Relations of the Medical Profession, State of Michigan"	401
"Three Publics Appraise Prepayment Medical Care"	403
"Should Industry Support Federal Health Insurance"	405
"Should We Have Compulsory Health Insurance"	405
President Truman's Plan	406
"Highlights of a Survey on the Associated Hospital Service of New York"	406
Comments	407

CHAPTER XIX. POPULATION COVERAGE UNDER MEDICAL INSURANCE

Dependents	408
Economic Status	408
Occupational Status	410
Age	411
Universal Coverage	412
Exclusions	412

CHAPTER XX. BENEFITS

Benefits Generally	414
Services Excluded	414
Type of Payment for Benefits	416
Cost of Professional Services, Generally	416
Physician Service	417
Eye Refraction	423
X-Ray	423
Laboratory Service	426

Physiotherapy	427
Visiting Nurse Service	427
Dental Service	427
Hospital Service	431
CHAPTER XXI. PROVISION OF BENEFITS	
Participating Physicians and Dentists	434
Medical and Dental Groups	435
Diagnostic X-Ray and Radiotherapy Service	444
Clinical Laboratory Examination	445
Visiting Nurse and Home Nursing Service	445
Hospital Service	445
Other Services and Participants	446
Authorization of Services	446
Acceptance of Patients	448
Payment of Physicians and Dentists	448
Payment of Other Services	452
Methods of Billing for Payment	453
CHAPTER XXII. REVENUES FOR MEDICAL CARE	
General Characteristics	454
Financing Through Individual Contributions, by Taxes on Wages	457
Financing Through General Taxes	462
Financing Through Individual Contributions, by Tax on Personal Income	463
Miscellaneous Methods	465
Revenues for Medical Insurance in New York State	466
CHAPTER XXIII. ADMINISTRATION AND RESEARCH	
Administrative Agency	477
Policy Making	477
Executive	478
Local Administration	479
Budgetary and Financial Practice	480
Administrative Controls	480
Participation by Private Plans	481
Public Education	484
Research	484
CHAPTER XXIV. SUMMARY	485

PART 3

PUBLIC OPINION ON MEDICAL INSURANCE, NEW YORK STATE
SURVEY CONDUCTED FOR THE COMMISSION BY SURVEYS INCORPORATED

FOREWORD	488
SUMMARY OF FINDINGS	489
QUESTIONS AND RESPONSES	
Attitudes on Medical Insurance Generally	491
Coverage by Cost Sickness Benefits	492
Coverage by Hospitalization Insurance	493
Incidence of Hospital Treatment	495

Coverage by Medical Care (Physician) Insurance	495
Incidence of Physician Treatment	497
Medical Insurance vs. Pay-As-You-Go	498
Compulsory or Voluntary Insurance	499
Population to be Covered	502
Employer Contribution	503
Cash Sickness Benefits	504

PART I

REPORTS AND RECOMMENDATIONS OF COMMISSION MEMBERS

MAJORITY REPORT

When this study was undertaken by the Commission on Medical Care, the task was defined by the Governor as one of devising a plan to make medical care more available to all classes of people in the State of New York. It soon became apparent to the Commission that the insurance or prepayment principle is the one which best could be employed to attain this objective. The New York State Commission on Medical Care is not prepared, however, to recommend to the Legislature any plan for medical care insurance and hospital insurance financed on a compulsory basis. After careful study of the subject, certain principles have become apparent. These are:

1. Adequate medical care should be made more readily available to all residents of the State.
2. The persons to be benefited should pay a material part of the cost.
3. There should be freedom of choice of doctor by patient and of patient by doctor.
4. There should be as little government interference in the practice of medicine as is consistent with proper standards of medical service.
5. Good voluntary medical and hospital insurance plans should be encouraged.

A comprehensive plan for medical care includes hospitalization; physician's care at home, in the office, and in the hospital; nursing care; diagnostic services; and limited dental care. The cost of this type of plan covering every resident of the State has been variously estimated, but it would probably be at least \$400,000,000 a year. This would mean a cost of at least \$30 per capita.

The Commission is of the opinion that this sum represents too great an expenditure to be imposed on the people of the State, either directly or indirectly through governmental authority, until there has been more

experience in the field of medical and hospital insurance.

There would be serious difficulties in administering medical care to thirteen million people and avoiding abuses and deterioration in the quality of service. Furthermore, the facilities in the State with respect to medical, dental, nursing and hospital care would need to be greatly expanded.

The Commission, unwilling to recommend an experiment on such an enormous scale and at such cost and risk, endeavored to find some plan less than a comprehensive plan which might be used to test out the practicability of a compulsory prepayment plan of medical care. In this it has been unsuccessful. There appeared to be no plan for medical care financed on a compulsory basis, less than comprehensive, upon which the Commission could agree.

It is true that the Commission has not brought forward a comprehensive medical care plan for the State of New York. The purpose of the Commission's study was to recommend to the Legislature what in its opinion would improve medical care for the citizens of the State. The Commission has studied the question for some fifteen months and has come to the conclusion that to make an experiment in a field heretofore non-governmental and an experiment at such great cost and affecting thirteen million people, is something which deserves further study before definitive action is taken.

The Commission recognizes that there are many factors bearing on the subject of health, e. g. better housing, nutrition, etc., but would like to recommend that consideration be given to the following:

1. Extension of public health and welfare services.
2. State aid for hospital construction.
3. Development and extension of diagnostic aid facilities.
4. State support for specific medical research projects.

Msgr. John J. Bingham
 Harold R. Brown, M. D.
 Andrew A. Eggston, M. D.
 Agnes Gelinas, R. N.
 Edward S. Godfrey, Jr., M. D.
 *Frederick MacCurdy, M. D.
 Lee B. Mailler
 Herman G. Weiskotten, M. D.
 Garrard Winston

*Approved with reservations.

MINORITY REPORTS

A number of the Commission members have found it impossible to subscribe to the report of the majority. These members are in agreement with the conclusion of the majority that the principle of spreading the costs of medical care on the insurance or prepayment principle is the one which could best be employed to attain the objective of making adequate medical care more readily available to the people of the State. With one exception, however (Minority Report No. 3) they do not agree that no plan can be recommended to the Legislature for definitive action.

The differing plans and courses of action which are recommended by different members or groups of members within the minority are presented in the form of separate minority reports.

MINORITY REPORT NO. 1

A PROGRAM PROVIDING COMPREHENSIVE MEDICAL, DENTAL, HOSPITAL AND NURSING CARE FOR CHILDREN UNDER EIGHT YEARS OF AGE IS RECOMMENDED TO THE LEGISLATURE FOR ADOPTION.

Such a program would provide a modest and realistic approach on an experimental basis to the problem of making adequate medical care more readily available to the people of the State. It has been suggested repeatedly that experience in this field should be acquired through a program which would have the features of comprehensive benefits, financing on a compulsory basis, and coverage of persons at all economic levels, but which would not attempt to cover thirteen or more million people. The possibility of selecting limited geographic areas of the State for such an approach was explored, but it was not believed feasible for the State to employ its funds for this purpose, nor for the State to compel persons within limited areas to finance such a program. However, the Commission's studies and researches, its conferences with groups representing all phases of public and special interests, and the scientifically gauged opinion of the people of the State as a whole have convinced us of both the desirability and feasibility of a program covering children throughout the State.

Children under eight years of age number about 1,340,000, or approximately one-tenth of the State's population. The selection of this group, which numbers little more than one-half of the number of participants in one of the voluntary hospitalization insurance plans, would not present the administrative difficulties which might be experienced in the coverage of more than thirteen million people. The lesser cost entailed and the smaller number of persons involved would reduce to a minimum the fears that have been expressed by the majority in respect to developing revenues and assuring adequate facilities and personnel for a group ten times as great.

Because the greatest need and hope for accomplishment in the prevention and relief of disease and disability is during childhood, it is especially fitting that the program should provide adequate medical care to children in the formative years of life. Such a program would be entirely consistent with the wise and progressive system that has been developed by the Legislature for the education of the children of New York State. If experience with the program should indicate the desirability of extending the program beyond this age group, a pattern would have been provided for an orderly and sound evolution.

The program recommended is conceived as one which would be closely intergrated with and would not duplicate the systems of health education, communicable disease prevention and child guidance which have been entrusted by the Legislature to departments of public health, education and mental hygiene. Also, the program is one which preserves to the medical, dental, and nursing professions and the hospitals their freedom and integrity and does not contemplate the provision of care through physicians, dentists, nurses or institutions in the employ of the State.

The intrinsic features of the program are, in brief:

1. Coverage. All children under 8 years of age resident in New York State would be covered.

2. Benefits. The benefits to be provided would include all necessary medical, dental, nursing and hospital care.

The maximum costs, estimated on the basis of complete fulfillment of medical and dental needs computed at adequate professional fees (roughly corresponding to those paid under Workmen's Compensation in the case of physicians), and actual hospital costs, would be as shown below.

	<u>Services</u>	<u>Annual costs</u> <u>(millions)</u>
<u>Physicians' services</u>		
Care and treatment, home, office and hospital cases		\$34.5
Health supervision and immunization		10.0
Physiotherapy - home and office cases		0.2
Visiting nurse service		0.5
X-ray and laboratory service - home and office cases		1.0
Hospital care and nursing, physiotherapy, x-ray and laboratory service in hospital		16.5
Dental care		9.0
Total		71.7
<u>Administration and research</u>		
Administration		0.2
Research		0.2
Total		5.3
Grand total		77.0

3. Provision of benefits. All physicians and dentists, singly and as groups, would be eligible to provide medical service to children. Diagnostic x-ray service would be provided by hospitals, hospital out-patient departments, public laboratories, and by qualified private radiologists (in addition, x-ray services relating to fractured extremities, etc. might be provided by any licensed physician, and dental x-rays by any licensed dentists. Laboratory service would be provided by approved hospital, pub-

lic and private laboratories. Any hospital would be eligible to participate in the program. Visiting nurse service would be provided by non-profit visiting nurse associations and official public health nursing agencies.

4. Payment for service. Physicians and dentists desiring to be assured of payment in full could elect to receive the full amount of the State fee schedule, in return for which they would forego the right to make any extra charge to the patient. Other physicians and dentists could reserve the right to make charges in excess of the fee schedule with the understanding that payments to them would be pro-rated if the funds appropriated for the purpose did not prove to be sufficient. Visiting nurse service, x-ray and laboratory examinations and physiotherapy treatments could not be charged for at rates in excess of the fee schedule. An allowance fixed by the State on the basis of actual operating costs would be paid to the hospital, extra charges being permitted only for more expensive accommodations such as private rooms.
5. Administration. The program would be administered by an official State agency. A policy-making board empowered to make regulations would be appointed by the Governor and would consist of two physicians, one dentist, one hospital administrator, one nurse, five members at large and the executive of the State agency. In addition to the professional representation afforded by the membership of the board, there would be adequate representation through official advisory committees. Local administration would be on the State district system employed by a majority of the existing State departments, with appropriate local advisory councils. The executive would be a physician, experienced in administration, appointed by the Governor and responsible to him, although dependent upon the board for advice and for the enactment of regulations.
6. Revenues. No recommendations are made concerning the financing of the program, which is believed to be a matter for decision by the Legislature. It is pointed out that a registration fee might be imposed to bring the program into conformity with the principle that the persons to be benefited should pay directly a part of the cost. Inasmuch as the direct beneficiaries would be young children, the fee should be nominal in amount. If the Federal Maternal and Child Welfare Act of 1945 (S.1318) were enacted,

17

this program for New York State would stand to benefit substantially, perhaps to the extent of \$10 million.

A HOSPITAL LICENSURE LAW IS RECOMMENDED TO
THE LEGISLATURE FOR ADOPTION.

The quality of hospital care, which is an integral part of any medical care program, has been improved through the efforts of non-official bodies such as the American Medical Association, the American Hospital Association, and the American College of Surgeons, and of the boards and staffs of the hospitals themselves. These are all voluntary, non-official undertakings, however, and do not and cannot affect hospitals which may be heedless of the need for good standards.

A measure of supervision is exercised by the State Department of Social Welfare under the authority of Article XVII of the State Constitution. However, such authority is indirect and deficient owing to the fact that a hospital must be considered a charitable institution to come under its jurisdiction. Certain general and special hospitals, and numerous convalescent and nursing homes are subject to little, if any, regulation and supervision. Further, the organization of the State Department of Social Welfare does not at present provide for representation of such interests as physicians, nurses and hospital directors in dealing with hospital regulation.

It has been considered necessary under a number of public programs to provide for inspection of hospitals and related institutions to supplement the inspections of the State Department of Social Welfare or to cover institutions not so inspected. A hospital licensure law would aid in improving the medical care received by the people of New York State through the development and enforcement of good standards of care in the many institutions not now under supervision. No additional burden would be placed upon the hospitals now subject to supervision; in fact, a special committee of the New York State Hospital Association has informed the Commission that the hospitals would "welcome one authority and one real inspection, and the avoidance of further duplication of authority and inspection." Also, the American Hospital Association has urged the States to adopt a system of licensing and supervision of hospitals.

THE PROVISION OF HOSPITAL CARE FOR TUBERCULOSIS AND MENTAL DISEASE
AT PUBLIC EXPENSE IS RECOMMENDED TO THE LEGISLATURE.

The Legislature has wisely provided that the diagnosis and treatment of venereal disease, and the care of patients in county tuberculosis hos-

pitals be provided at public expense unless the recipient chooses to pay from his own resources for such care. It is assumed that the underlying reasons were that submission of a patient to care or treatment benefits the community as much or more than the patient, and that the patient may be required by legal process to submit to such care or treatment.

The requirement that a patient pay for care in a public tuberculosis hospital if he is judged by a means test to be able to do so undoubtedly deters a number of patients from undergoing hospital care. The result of this policy is often a continued spread of the disease and continued costs to the public for the care of cases arising from infectious cases who were not hospitalized. Attention is called to the statement of the New York City Department of Health that "the cause of tuberculosis would be greatly augmented in New York City if the cost of hospitalization was borne entirely by the city, and if no means test would be applied to persons in need of treatment." It seems clear that the principle of community responsibility for hospitalization of the tuberculous as exemplified by Chapter 585 of the Laws of 1945 (County Law, Section 49-a), should be applied to the entire State.

State hospitals for the treatment of mental disease require payment by the patient or legally liable relatives (husband, wife, father, mother and children) to the extent of ability as determined by a means test. The discontinuance of this practice is recommended because the mentally ill patient abroad in the community may menace the public health and safety, and because he may be compelled by legal process to submit to hospital care. As is true of tuberculosis, the welfare of the community would be promoted if no means test were applied to persons in need of institutional treatment.

At present, inadequate public provision is made for patients chronically addicted to drugs or alcohol. Patients with these conditions cannot be admitted to State mental hospitals unless some other type of mental disease is present. It is urged that consideration be given to permitting admission of patients of this type to State mental hospitals and the provision of special facilities for the care of these conditions.

Lucien Brown, M. D.
Ruth Hall, R. N.
Sen. Frederic E. Hammer
Basil C. MacLean, M. D.
Marion W. Sheahan, R. N.

MINORITY REPORT NO. 2

When Governor Dewey, on September 5, 1944, announced the appointment of the members of the Commission on Medical Care, he declared that "the purposes of the Commission are to make necessary studies, in order to devise programs for medical care for persons of all groups and classes in the State of New York." On September 30, 1944, the Governor's Counsel, Charles D. Breitel, reported to the Chairman of the Commission Governor Dewey's statement to him that "the people he had in mind were the middle class who are not receiving adequate care and that he is not limiting his interest to the indigent sick."

The Commission on Medical Care began its work on October 25th. It then consisted of seventeen members, representing both Houses of the Legislature, members of the medical profession, the Commissioners of Health, Mental Hygiene and Social Welfare, nurses, a hospital administrator, a representative of the Catholic Charities and a business man. Its Study Staff commenced its research on November 1st, 1944. At the insistence of the State Medical Society, two additional physicians were appointed to the Commission later.

From the beginning, the Commission considered as its task, not only to obtain detailed information on the medical resources and needs of New York State and on the methods by which such needs might be met, but before all "to formulate a program for legislative action and to do so within the shortest period consistent with the researches and deliberations necessitated by the important social and economic aspects of the problem." Frequent discussions among the Commission members during meetings of the first ten months invariably confirmed the understanding that in asking the Commission to report to the Legislature on or before February 15, 1946, the Governor wishes the Commission to offer, not only a program complete with respect to details of coverage, benefits, administration and finance, but recommendation for legislation.

The Commission worked well for the first year. The Study Staff, under the direction of Dr. Paul Lembcke, assembled for its members a mass of material and data.

The need for a medical care program was never in doubt, as it was clearly shown, not only by the large number of rejections for health reasons by Selective Service, but by all surveys and examinations of large numbers of people. Nor was it ever doubted that by far a disproportionate number of the people suffering from ill health come from a group of persons for whom medical care is not readily available because of their

economic status.

It was also clearly established through the study of a number of surveys of public opinion that the people of the United States want, and would be willing to pay for a medical care program which would make available to them comprehensive medical care and would also remove the threat of sudden doctors and hospital bills which they are unable to meet.

I refer to the surveys conducted by Fortune Magazine, by the Physicians Committee on Research, Inc., (through the National Opinion Research Center) and especially to the latest national public opinion poll conducted by the Opinion Research Corporation for the National Physicians Committee for the extension of medical service (November 1945). This last group is absolutely opposed to compulsory medical insurance in any form. All these surveys disclosed that the majority of the American people whenever given a chance will express their desire for a pre-payment insurance covering hospital care and complete medical and surgical care in the home, doctor's office and hospital. Moreover, the majority would consider a Government Plan with payments legally required to cover the benefits such a plan would offer them, as the best way to improve the health of the people. Let me quote some figures obtained by the poll for the National Physicians Committee. Seventy-five per cent of the persons who were polled, said "Yes, something could be done to make it easier for people to pay for doctor and hospital care " (an increase of eight per cent over a similar survey in 1943) Asked whether they would consider a Federal Government Plan - "A good or a bad thing for the nation as a whole" - fifty-five per cent thought it would be a good thing, while another eight per cent saw some possibility of good in it.

So much for polls conducted on a national scale.

The people of New York State have shown even more decisively their willingness to accept health protection by state insurance. They voted in 1938 that nothing in our constitution "shall prevent the Legislature from providing for the protection by insurance or otherwise, against the hazards of.....sickness....."

In January 1946 the Commission itself conducted a poll throughout New York State. This poll - taken 40 per cent in metropolitan New York - and 60 per cent upstate - shows that 86 per cent of those questioned think everybody who lives in New York State should have insurance which pays doctor and hospital bills. 51.9 per cent would like a compulsory government health plan for everyone - with insurance payments graded according to family incomes.

The alternative possibilities of voluntary insurance versus a government plan were thoroughly explored in the early studies of the Commission. In spite of the comparatively fast growth of voluntary insurance plans, less than 20 per cent of the people of New York State are today members of such plans; moreover most of these people have hospitalization insurance only, and no physician's services. Even strong proponents of voluntary insurance have to confess that it will not be possible to cover all the people of the State who need such coverage and that only legislation requiring payments for health insurance would accomplish that purpose.

After very thorough investigation three plans were developed by the Commission for discussion with interested groups. All three plans shared one feature - compulsion - but only one (Plan #2) made even an approach to being comprehensive. None of the proposals incorporated physician's care at home and office. In other words, none of these plans included comprehensive medical care, although it was admitted (in the preliminary report) that this would be highly desirable. The reasons for this serious omission will appear later.

Private conferences on the three "Alternative Plans for Medical Insurance in New York State" were held during September and October 1945, with representatives of the medical, nursing and other professions involved, and with representatives of hospitals, medical insurance organizations, labor, industry and agriculture.

It was planned that these private conferences should be followed by further discussion among the Commission members, which would lead to the development of a final plan. This plan was to form the subject of public hearings, to which representatives of the "consumers of health insurance," i.e. the public at large were to be invited.

In general a study of the conference reports shows that:

- 1) Only the State Medical Society and the commercial health insurance companies questioned the need for compulsory health insurance. They wanted any governmental action confined to paying for the indigent.
- 2) The State Dental Society and the non-profit medical and hospitalization insurance organizations did not advocate compulsory medical insurance, but seemed content to leave the decision to the people and the Legislature.
- 3) Labor was in favor, not only of compulsory medical insurance, but of much more comprehensive insurance than was contemplated in any of the Commission's plans. The representatives of labor declared that employees would be willing to pay their share of the cost of comprehensive health insurance through payroll deduction.

4) Representatives of industry were divided in their opinions; while in general they were not opposed to a state plan, some felt that the employer should not have to share contributions with the employee - while others judged from their experience with 100 per cent company-financed health services that employer contributions were feasible.

Practically all groups, whether they were opposed or favorable to compulsory insurance, felt that home and office visits by physicians should be included, as the preventive features of any plan were most important for the health of the people.

These conferences further proved that the method of payment for physicians suggested by the Commission's plans - namely, fee for service according to an inelastic unit fee schedule was not regarded as the only feasible or desirable method of remuneration.

It was also pointed out by several groups, especially by the representatives of labor, that the per capita premium which had been suggested by the Commission as part of the financing for any health insurance plan would constitute a burden on the low income groups and that straight taxation would be preferable.

I shall discuss later the reasons named by the State Medical Society and the commercial health insurance companies, for their opposition to any kind of compulsory insurance and I shall, therefore, only enumerate them at this moment.

Representatives of these bodies stated:

1) That the demand for insurance had been stimulated by people interested in health administration and was not a real popular demand.

2) That moreover, no need for such insurance exists and that any one who is in need of medical care can now get it.

3) That the Commission should limit itself to plans for more care for the indigent (perhaps making it possible for anyone to receive care after a means test) and should leave the rest of the field to the voluntary insurance plans.

4) In addition to such basic opposition, the above mentioned groups stated that we have no experience whatsoever in the administration of compulsory plans, and that there will be too much abuse by doctors and patients as, they declared, has been proven by the administration of the Workmen's Compensation Law.

Every one of these statements had previously been disproved by the Commission's own painstaking research. This reference material was available to all members of the Commission. Therefore, it seemed only natural

to expect that at its next meeting the Commission, after due analysis of the opinions and advice of all organizations heard at the special conferences, would combine this new knowledge with its own previous conclusions and would vote to work out for final recommendation to the Legislature a plan based essentially on its own Plan #2, but more comprehensive in scope of service and with revised methods of paying the physicians and of raising the necessary funds.

It didn't happen that way. In the interval between the conferences and the next Commission meeting, five alternative plans were developed. Among these was one comprehensive plan. Nevertheless, at the next meeting, November 1st, 1945, the majority of the Commission members voted against even the discussion of any of these plans and decided not to recommend any plan to the Legislature. Thus the Commission completely reversed its position as to the task set for it by the Governor. The results of more than one year's research by the Study Staff were discarded. I can only conclude that this change of position on the part of the majority of Commission members was due to pressures exerted upon them by special interests; the only apparent pressure was that by the leaders of the State Medical Society. At the Commission's private conferences with these leaders they refused even to consider the actual features of comprehensive health insurance. They fought instead what they called "socialized medicine."

It is hard to see how any one can fail to see the vast distinction between socialized medicine and comprehensive health insurance. It has become obvious during recent years, when health insurance has been widely discussed, that these leaders of the State Medical Society do not truly represent the large number of physicians, but only a small group of obstructionists. I need only refer to the report on "Principles of a Nationwide Health Program," (published by the Committee on Research on Medical Economics, November 1944) in which leading physicians, together with experts from other fields, declared that "to meet the need (i.e. medical care for all the people) public action is required on a nation-wide scale, as well as action by voluntary organizations and by individuals in their own behalf."

What were the so-called factual reasons which caused the majority of the Commission to disregard the task which was clearly defined by the Governor and which was originally accepted by the Commission? What was responsible for the dismal failure of the Commission in its duty to the people of New York State?

Some of these "factual" reasons were stated by majority members at the meeting November 1st, 1945, as follows:

- 1) No compulsory plan is necessary because the voluntary plans have made great strides and should be given a chance for full development.
- 2) Any compulsory plan would be too difficult to administer, as we have not had experience in this field.
- 3) A compulsory plan offering comprehensive service would invite too much abuse -- by the patient if fee for service were the method adopted for payment to the physician, and by the physician if he were paid on a per capita or a salary basis.
- 4) A compulsory plan would deteriorate the quality of medical care.
- 5) A compulsory plan offering comprehensive service would be too expensive.

Each of these objections will collapse under the light of experience and knowledge if it is disinterestedly interpreted with the welfare of all the people in mind.

1) Voluntary plans have done a good job in the field of hospitalization insurance. They have contributed, and are contributing now, valuable experience. They have however made little progress in providing physicians' services. Less than 500,000 persons in New York State have insurance for some physicians' care, whereas approximately four millions have Blue Cross or other insurance under voluntary plans. Yet altogether less than one in four of our citizens has been reached by these plans at all.

During the last five years the growth of voluntary insurance in New York State has been very rapid, jumping from 13 per cent of the population in 1939 to over 20 per cent now. This growth may be due to some extent to the war-time rise in income. Even if this rate of growth were to continue, however, only approximately 40 per cent of the people in New York State would be covered by 1959. Moreover because of their necessarily selective policy and their fixed rates, which are not adjusted to varying incomes, voluntary insurance plans are not well suited for those who need care most, namely, the large group of low income people who nevertheless would not pass a means test and, therefore, are not and would not be entitled to free medical care.

There are other reasons preventing a more rapid growth of voluntary insurance plans. A survey conducted in 1943 by Elmo Roper for Associated Hospital Service of New York disclosed that of the people who were questioned and were not insured, almost 50 per cent gave as their reason that the plan did not include doctors' bills, while another 20 per cent felt

that in general the plan did not offer enough benefits.

The Commission explored thoroughly the various ways of "materially extending" the coverage of voluntary insurance plans. Leaders of the major plans themselves suggested, for instance, such expedients as, 1) income tax deductions to provide increased coverage, 2) compulsory enrollment of the relief population, 3) mandatory collection of premiums by employers at the request of a majority of employees, and 4) legislation permitting the issuance of a single policy covering medical and hospital insurance. In other words these leaders of voluntary plans call for compulsion!

If the health of the people is the concern of all of us, it is our duty to provide the necessary methods to insure this health now. We have no right to wait a long number of years in the hope that perhaps at some date in the future this urgent problem may be taken care of.

2) As far as the principle of compulsory insurance is concerned, we do have experience. Although we have not as yet had any experience in the actual administration of either statewide or nationwide compulsory health insurance in this country, we have a vast reservoir of knowledge and long experience to call upon from elsewhere throughout the world. Compulsory health insurance is established now in over thirty countries, and has been steadily expanding.

In the United States we have had in operation for many years industrial plans and union plans. In New York State I may mention the successful plans of the International Ladies' Garment Workers Union, Endicott Johnson, Consolidated Edison and similar groups. Recently we have had plans initiated by hospitals and medical societies. These plans and others were studied by the Commission. From them valuable knowledge is obtainable about the problems of voluntary plans and the administration of health insurance in general.

Let me also stress that we had no experience when this state introduced social security and workmen's compensation legislation, the first state in the Union to do so. Is it reasonable to say that we should not have adopted such legislation because of a lack of previous experience? Would such premises ever make new legislation possible?

3) It is argued that a compulsory plan would bring with it much abuse and that it should therefore be opposed. I agree that a small proportion of both doctors and patients will abuse their rights and privileges under any plan and that these abuses must be controlled. Some plans will offer more opportunities for abuse than others if unwise methods of

organization, payment and administration are pursued. In any case there must be:

a) Methods which enable physicians to be responsible for the quality of service, with competent medical men in appropriate positions to protect both the public interest and the interests of the physicians.

b) Methods of organizing service and of paying the physicians which maintain professional efficiency, assure adequate compensation and promote economy in operation.

c) Methods which assure to both patients and physicians the right to make complaints, to have them duly heard and redressed, and to be protected, through appeal, against incorrect or arbitrary decisions. Issues wholly medical in nature should be determined by medical men.

The administration must be organized in such a way that local bodies and advisory committees, consisting of representatives of the medical profession and the public at large, can keep in closest touch with developments on the local level and from time to time make necessary adjustments. This would provide self-control on the part of doctors and on the part of responsible representatives of the "patients". I have confidence in American physicians and I don't believe that many of them will abuse a plan which will help them attain their highest aims - the health of our people. And I believe that doctors will continue to strive to render a high quality of medical care. No profession has higher ethical standards. I am convinced that we can count on them to support these standards jealously, against offenders within their own ranks or elsewhere.

4) Offenses committed in the past can mostly be attributed to economic needs. Physicians like every one else may perform low-quality work if under economic pressure. Once a comprehensive health insurance plan is in effect people will go to their physician when they need a physician - physicians will work with less fear of economic distress and there will be less temptation to cut ethical corners or to create a livelihood artificially.

Specific methods to accomplish these aims are spelled out in the bill which I have introduced and which is referred to later in this report.

5) It is claimed that a comprehensive compulsory plan would be too expensive and that the necessary funds could not be raised. Let me first consider the cost. The cost of comprehensive care was estimated by the Commission's Staff as 315 millions for physicians' services alone. I agree that such a cost would be practically prohibitive, but I consider the Staff estimates were incorrectly made and that they are greatly in excess of any reasonable cost. Even the recent revisions which brought

the figure down somewhat are very high.

The Staff estimates were obtained by an academic procedure. All calculations were based on the so-called Lee-Jones Study (THE FUNDAMENTALS OF MEDICAL CARE, BY DR. ROGER I. LEE AND L. W. JONES - 1933). That study estimated what would be fully adequate care in each of the chief diseases, and then computed the total volume of services required for a given population, allowing for the expectancy of disease, age distribution of the population and standards of medical practice. By then fixing a fee for each type of visit, test, operation or treatment, the cost of medical services for the average course of each disease was computed. This result expresses a wholly theoretical figure.

The only practical way to deal with cost is first to give careful study to the existing expenditures for physicians services, hospitalization, nursing and other forms of medical care. The Commission made such estimates. For physicians' services, just before the war, the annual cost was estimated as \$170,000,000. Under a comprehensive health insurance system, somewhat more services would be demanded of physicians. It is reasonable that they should receive larger compensation. An addition of 25 per cent would be fair. The Staff estimate of over 300 millions would have meant an increase of well over 50 per cent.

The Staff estimated that 24,000 physicians would be available in New York State for participation in a comprehensive plan. I believe this figure is excessively high. The Staff made entirely insufficient deductions for physicians who have retired, or who fill full-time salaried positions. I consider a figure of 20,000 to be nearer the truth. According to Department of Commerce figures the average net income of non-salaried physicians in New York State was \$4,680 in 1941. Their average gross income must, therefore, have been approximately \$7,800 per year. On either of the above estimates, however, the income of physicians would be substantially increased under health insurance.

No one maintains that physicians have been over-paid or that they should not receive larger incomes under a comprehensive health insurance plan. These considerations, however, do not justify the tremendous increase considered by the Commission.

While the Commission's Staff allowed for tremendously increased physicians incomes it was extremely pessimistic in its estimates of the taxable base on which income payments for a compulsory plan would have to be calculated. The taxable income for New York State in 1941 was 10.3 billions. The Commission expects only a 10 per cent increase over 1941 in

the taxable income of postwar years. While it is impossible to give exact estimates at this time I maintain that such low figures are defeatist and that an increase of 25 per cent to 30 per cent is more realistic.

The above mentioned reasons have led me to believe that it is not only possible to develop an effective comprehensive health insurance plan for the State, but that it is possible now to provide such a plan and to raise through payroll deductions and taxation the funds necessary for its operation. I do not believe we would thus burden the industries, the farmers or the general public of this State. I was confirmed in my convictions, not only by a close and objective study of the Commission's reference material, but by the judgment of experts who have given long years of study to the problem of health insurance.

I have, therefore, introduced into the New York State Legislature on January 14, 1946, an Act to amend the public health law, in relation to providing for the organization and operation of a comprehensive statewide system of health insurance. In doing so I was guided by the principles originally expressed by the Commission, namely, that

- 1) The need of a medical care program is clearly evidenced.
- 2) The health of the people is a matter of public concern, as disability in adults impairs the productive capacity and therefore the economic development of our country.
- 3) The people themselves are willing to pay for their health insurance, as has been abundantly proven through surveys.

In this connection it is important to point out that the contention by the foes of comprehensive insurance that an enormous financial burden would be added and that taxpayers would not be able to carry that burden is fallacious. Let me refer to the report of the "Health Program Conference." This report states that "the American people are now spending for physicians' services and hospitalization enough to provide for all with only minor supplementation, if these payments are regularized, instead of falling with disastrous uncertainty." To be more exact - and I quote from the same source - "American families ordinarily spend directly about 4 per cent of their earnings for all kinds of medical services. Of this, the expenditures for physicians and for hospital services constitute about three-fourths, i.e., about 3 per cent of annual income. The percentages are larger among low-income groups." Another source, the U. S. Department of Commerce (W.H. Shaw, Survey of Current Business, June 1944, estimates 4.35 per cent of the total consumer outlay for all forms of medical care.

The main features of my comprehensive health plan are identical with

those of the Wagner-Murray-Dingell Bill and my plan would fit easily into the National Health Plan which is being considered and which I fervently hope will become law in the near future.

My bill provides for,

- 1) Comprehensive coverage of the people.
- 2) Comprehensive scope of service.
- 3) Just and equitable distribution of cost.
- 4) Freedom of choice for physicians and patients.
- 5) Adequate payment of physicians and hospitals by methods which are easily adaptable to varying conditions.
- 6) Continuance, within the framework of the general system, of voluntary plans which provide or organize services and which meet acceptable standards.
- 7) Encouragement of group medical practice with hospitals as professional service centers.
- 8) A policy determined by both physicians and representatives of the consumer.
- 9) Local administration of services with over-all standards.
- 10) Adaptation to a nation-wide system of health insurance when that is enacted by Congress.

If the Commission on Medical Care had correctly interpreted its own findings - this plan would have the votes of all Commission members. Certainly the Commission's own poll has proven that the people of New York State regardless of party affiliation want it and will enthusiastically support it.

February 12, 1946

Leonard Farbstein
*James A. Corcoran

*Senator James A. Corcoran joined the State of New York Commission on Medical Care late in 1945, after the resignation of former Senator - now comptroller of New York City - Lazarus Joseph. This report was therefore prepared by Assemblyman Leonard Farbstein, a member of the Commission from the start, both for Senator Corcoran and himself.

MINORITY REPORT NO. 3

The majority of the Commission has concluded, after careful deliberation during a period of fifteen months, that it would be unwise, at this time, to recommend to the Legislature any specific plan for medical care or hospital insurance financed on a compulsory basis.

A comprehensive program should include hospitalization; care by a physician at home, in the office and in the hospital; nursing; diagnostic services; and certain forms of dentistry. The cost of such a plan, covering every resident of the State, has been variously estimated. It would probably amount to at least 500 million dollars a year; this would mean a cost of approximately 35 dollars per capita.

This sum represents too great an expenditure to be imposed upon the people of the State through governmental authority until a wider experience has been accumulated in the field of medical and hospital insurance.

There would be serious difficulties in administering compulsory and comprehensive medical care to 13 million persons in a manner which would avoid abuses and deterioration in the quality of service. Furthermore, hospital facilities in the State would have to be greatly increased before such a plan could be put into effective operation. It would be necessary, also, to bring about a redistribution of physicians, nurses and dentists.

Because an experiment on such a large scale and at such great cost did not seem justified, attempts were made to devise a scheme affording only partial coverage. It was thought that a plan, limited either in the group insured or in the extent of service rendered, might serve as a pilot test. On analysis, it appeared that no plan, financed on a compulsory basis, was acceptable.

In the course of this study, certain principles have become apparent. These are:

1. Government interference in the practice of medicine should be confined to furthering and maintaining high standards of medical service.
2. Adequate medical care should be made more readily available to all residents of the State.
3. Under any insurance plan, the persons benefited should pay a substantial part of the cost and should be aware that they are paying it.
4. The development and expansion of well administered and medically efficient voluntary insurance plans should be encouraged.

It is suggested that immediate consideration be given to the following:

1. Extension of public health and welfare services.
2. Development and extension of diagnostic facilities.
3. State aid for the construction of hospitals.
4. Financial support from the State for specific medical and public health research projects.

Failure to propose a health insurance plan for the people of the State does not mean that the work of the Commission has been without profit. It has served to indicate that the time for definitive action, on a large scale, has not yet arrived. Any experiment involving one tenth of the population of the United States and costing half a billion dollars per annum, should be undertaken only when careful planning, based on sound premises, affords reasonable assurance of success.

Robert L. Levy, M. D.

MINORITY REPORT NO. 4

My chief disagreement with the report of the majority of the Commission on Medical Care is that the statement does not re-affirm a belief that social insurance represents the most practical means in sight for financing medical and hospital care for large numbers in the lower income groups'.

The possibilities of a social insurance plan for New York State have not been given an adequate review in the work of the Commission. The plans presented to the Commission were based upon the premise that they must cover every person in the state. No social insurance plan in the United States - workmen's compensation, unemployment compensation, and old age and survivors' insurance - has sought universal coverage at the outset. Nor has all-inclusiveness been achieved after many years of experience.

The one exception was a proposed scheme for medical care for all children under eight years of age in the State. This was universal to the extent of covering all children in the state regardless of economic status. This scheme was never elaborated to the Commission beyond a three-page letter, which was lacking in specific and substantiating details with respect to administration, finance, and relationships to existing health and medical services to children provided by public health and welfare agencies.

The problem of paying for and obtaining adequate medical and hospital care is today most serious in New York State for families with incomes ranging roughly from \$1200. to \$4000. per annum. In higher brackets of income, persons are better able to meet normal medical expenses and, for the most part, to finance catastrophic medical and hospital costs. The very poor are taken care of in ordinary and emergency medical situations through our systems of public medical care and hospitalization.

It is true that the Commission at an early stage went on record as favoring universal coverage in principle. In the plans presented to the Commission, however, the achievement of this principle seems to have outweighed practical considerations and to have resulted in proposals which, in part, are anti-social in their effect. For example, the plans presented to the Commission required an annual contribution from persons with gross cash income as low as \$500. a year. And if there was another dependent adult in his family - wife, mother, father or child over 18 - a wage-earner would be compelled to contribute for him, too. This is bad enough. But the plans provided in addition that local units of government should pay substantial funds to the state insurance fund, which it was assumed

they would be happy to do because they were relieved of having to provide free medical and hospital care for the needy! The poor would thus not only pay for themselves, but the localities would also chip in for the privilege of no longer having to pay for them.

The solution of our public medical and hospital care problem is primarily an economic one. The genius of our best brains in public finance, actuarial science, and public administration must be devoted to it. The severest indictment that can be made of us, the members of the New York State Commission on Medical Care, is that we did not insist that there be competent experts in social insurance and public finance on the staff serving us.

That the Commission has failed to develop a plan which it can recommend to the Legislature is regrettable, but there is no reason to be ashamed. After all, only one governmental insurance plan to cover medical care costs exists today in this country and this is limited in scope. We have reason to be ashamed only if we stop here. I urge the Legislature to find some device by which it may further pursue the project on which the Commission on Medical Care has been engaged.

Robert T. Lansdale

CHAIRMAN'S SUPPLEMENTARY REPORT

As Chairman, I have had an opportunity to review the majority and minority reports prior to their submission to the Legislature. After reading them I have felt an obligation to comment on certain factual statements which I believe to need clarification or correction. I shall refrain, however, from commenting on interpretations made in the other reports, which are a matter for individual opinion.

I am sure that all members of the Commission have recognized the difficult problems which faced the Director of Study and his staff, and have appreciated the excellence of the factual information that has been provided. A tremendous volume of work was imposed by the fact that, in addition to its researches and investigations, the staff was requested to prepare a great number of plans for consideration. The staff labored under the handicap that at no time did the Commission settle definitely enough on a course of action to permit the staff to make all of the pertinent researches that it would have desired. As an example, it was necessary to employ the New York State Workmen's Compensation Fee Schedule for illustrative purposes, although if a plan had been adopted in broad outline, further refinements with regard to costs and fees might have been made in consultation with interested and qualified parties.

In Minority Report No. 2 it is erroneously stated that the Commission's staff estimated that the cost of comprehensive physicians' services would be \$315 million. The actual figures supplied by the staff were: all physicians' services except eye refractions - \$258 million; eye refractions (physicians and/or optometrists) - \$13 million; total - \$271 million. The method by which the staff estimate of 24,000 practicing physicians was prepared has been described in detail in Part 2 of the Report, and must be considered more authoritative than an opinion that 20,000 is the more likely number. With regard to taxable income, the staff estimated a 20 per cent increase over 1941 for the postwar years rather than the 10 per cent mentioned in Minority Report No. 2.

In explanation of the statements regarding financing which are made in Minority Report No. 4, the plans presented by the staff to the Commission were based upon the guiding principles adopted by the Commission. The principle that the persons to be benefited should pay a material part of the cost has been re-affirmed in the Majority Report, and should be considered as the responsibility of the Commission rather than the staff. The advice of qualified persons eminent in the fields of public finance and taxation was obtained concerning the revenue principles which had been

adopted by the Commission and are presented in the chapter on revenues, PART 2 of the Report.

Early in its deliberations the Commission decided that an impartial survey of public opinion should be conducted at a time when specific information became available regarding the costs of plans of varying scope. Four plans which were similar in respect to benefits and costs to those approved by the Commission for discussion with representative groups were to have been included in the survey questionnaire. However, the Commission's Committee on Public Opinion Surveys, a group of four members, in November 1945 decided that public opinion should not be determined and, after the Commission as a whole affirmed its earlier decision that a survey should be made, the Survey Committee eliminated all reference to specific plans.

Attention is directed to PART 3 of this report, wherein the survey conducted for the Commission by an independent, impartial research agency reveals a majority to favor government-sponsored and operated medical insurance. Apart from the survey, there is presented herewith a memorandum received by me from Surveys Incorporated, the contents of which I believe should be brought to the attention of the Legislature.

Basil C. MacLean, M. D.

MEASUREMENT OF ATTITUDES OF NEW YORK STATE PUBLIC OPINION TOWARD
CERTAIN SPECIFIC PLANS FOR DOCTOR AND HOSPITAL INSURANCE

A Memorandum to Dr. Basil MacLean, Chairman of Commission on Medical Care,
from SURVEYS INCORPORATED, New York & Washington, February 1946.

Preface

As you will remember, the pre-testing of the public opinion survey for the New York State Commission on Medical Care included the ascertainment of the respondents' reactions, pro and con, to four various plans for doctor and hospital insurance. We received the descriptions of these plans from the Commission's staff. The final draft of the survey questionnaire, cleared with the consultants and advisers, contained that measurement of attitudes toward specific plans.

Just two days before the field work began, the measurement of attitudes toward those specific plans was dropped from the questionnaire to be used in behalf of the Commission. Upon careful consideration of the opinion research values which would be lost by the omission of such specifics and recognizing that their inclusion would not affect the questions in behalf of the Commission, it was determined that Surveys Incorporated would, on its own and without expense to the Commission, add those specifics for the respondents' opinions and would make this additional information available to you.

In accordance with customary practice, the client of Surveys Incorporated was not identified by the questionnaire in behalf of the Commission nor was it known even to the interviewers. Similarly, the additional questions were not identified with any client whatsoever.

We believe the findings regarding the specific plans will be of some value to your research on this subject. You are welcome to include these findings in any report you may make.

Findings

In each interview the field reporter read the explanation of "four various plans for doctor and hospital insurance which have been suggested for people who live in New York State." Then the respondent was asked to read the description of Plan One and was asked two questions concerning that plan. After this, the description of Plan Two was read, the two questions asked with respect to that plan, and similarly in the cases of Plans Three and Four.

68.8 per cent are willing to pay the amount listed for their family's income for Plan One, which would provide:

Visiting nurse service in the home for everybody.
 X-rays and laboratory tests and services for everybody.
 Care of the teeth of children under 8 years old.
 All doctor's services for children under 8 years old
 (including operations), whether at home, at the doctor's
 office, or in the hospital

24.8 per cent are not willing to pay the listed amount for that plan. If they were voting "in a State election, on whether or not this Plan One should be put into effect in this State," 63.7 per cent would vote for it and 25.4 per cent would vote against it.

60.3 per cent are willing to pay the amount listed for their family's income for Plan Two, which would provide all the services provided by Plan One and also:

Payment for all hospital expenses of everybody, for as long as hospital care is needed in each case - with the exception of tuberculosis and mental disease.

31.5 per cent are not willing to pay the listed amount for that plan. If voting on this plan alone in a State election, 55.2 per cent would vote for it and 31.1 per cent would vote against it.

49.5 per cent are willing to pay the amount listed for their family's income for Plan Three, which would provide all the services provided by Plans One and Two and also:

Payment of all doctor's bills for having a baby, including care both before and after the baby is born - at home, at the doctor's office, or in the hospital.

Payment of bills for surgical services and operations for everybody, including surgical care before and after operations - at home, at the doctor's office, or in the hospital.

41.0 per cent are not willing to pay the listed amount for that plan. If voting on this plan alone in a State election, 47.0 per cent would vote for it, 37.3 per cent would vote against it, and 15.6 per cent are undecided.

36.7 per cent are willing to pay the amount listed for their family's income for Plan Four, which would provide all the services provided by Plans One, Two and Three and also:

Payment of all doctor's bills for everybody: for all kinds of doctor's services, including operations - at home, at the doctor's office, or in the hospital.

52.8 per cent are not willing to pay the listed amount for that plan. If voting on this plan alone in a State election, 37.7 per cent would vote for it, 46.9 per cent would vote against it, and 15.2 per cent are undecided.

Those who were opposed or undecided on all plans totaled 17.5 per cent of all respondents. When asked their main reasons for their opposition, 36.3 per cent of them are "against government control," 24.4 per cent declare the plans "too expensive," 12.7 per cent do not know, and the balance is distributed among a dozen other reasons.

When asked, "If one of these four plans were put into effect in this State, which one of them would you prefer?" almost all of those who were opposed or undecided on all plans remained undecided or expressed no opinion. Of those who had favored more than a single plan, the greatest number gave their support to Plan Four when asked which one plan they would prefer.

Descriptions of the plans, and the answers to each question, follow:

EXPLANATION CARD

I'd like to ask you some questions about four plans for doctor and hospital insurance, which have been suggested for people who live in New York State. As you will see, each plan is different and would cost different amounts. The purpose of each plan is to provide to people who live in New York State insurance which will pay for doctor and hospital bills. Under each of the plans, everybody who lives in New York State would be covered by the insurance. They would be compelled by law to make their own payments to the State Government for it. The payments for the insurance would depend on the amount of each family's income. The more the family income is, the more the insurance would cost. Every family would choose its own doctor and hospital. People who already belong to doctor and hospital insurance plans (or to company and union plans) could still stay in them. Anybody who wants to join these other plans could still do so. The money these people and their employers pay to private plans would be deducted from the payments they would have to make to the State. Now, please read Plan One carefully.

PLAN ONE CARD

PLAN ONE would provide:

Visiting nurse service in the home for everybody.

X-rays and laboratory tests and services for everybody.

Care of the teeth of children under 8 years old.

All doctor's services for children under 8 years old (including operations), whether at home, at the doctor's office, or in the hospital.

LIST OF PAYMENTS UNDER PLAN ONE

IF YOUR FAMILY INCOME IS:

THEN YOUR FAMILY'S INSURANCE PAYMENTS
WOULD BE AT THE RATE OF (See Note below regarding single persons):

About \$10 a week (about \$500 a year)	None
" \$20 " " (" \$1,000 " ")	None
" \$40 " " (" \$2,000 " ")	None
" \$60 " " (" \$3,000 " ")	None
" \$75 " " (" \$4,000 " ")	About \$1.25 a month
" \$100 " " (" \$5,000 " ")	" \$2.50 " "
" \$150 " " (" \$8,000 " ")	" \$6.25 " "
" \$200 " " (" \$10,000 " ")	" \$8.75 " "
" \$400 " " (" \$20,000 " ")	" \$21.25 " "

Note: For single persons, there would be no payments for those in the two lowest income groups listed above. In most of the other income groups, a single person would pay about \$2 more a month than a family.

ATTITUDES ON PLAN ONE

Question On the list of payments, please find the amount you would pay under this Plan One, according to your family's present income. (Pause) For this plan, would you be willing to pay the amount listed for your family's income?

Response:

Yes.....	68.8 per cent
No.....	24.8
Don't know.....	6.4
No information.....	<u>0.0</u>
Total	100.0

Question If you were voting, in a State election, on whether or not this Plan One should be put into effect in this State, would you vote for it or against it?

Response:

For.....	63.7 per cent
Against	25.4
Undecided	10.8
No information.....	<u>.*</u>
Total	100.0

*Less than 0.1 per cent.

PLAN TWO CARD

PLAN TWO would provide:

All the services provided by Plan One, and also:

Payment for all hospital expenses of everybody, for as long as hospital care is needed in each case - with the exception of tuberculosis and mental disease.

LIST OF PAYMENTS UNDER PLAN TWO

IF YOUR FAMILY INCOME IS:

THEN YOUR FAMILY'S INSURANCE PAYMENTS
WOULD BE AT THE RATE OF (See Note below regarding single persons):

About \$10 a week (about \$500 a year)	About \$1.00 a month
" \$20 " " (" \$1,000 " ")	" \$1.20 " "
" \$40 " " (" \$2,000 " ")	" \$2.40 " "
" \$60 " " (" \$3,000 " ")	" \$3.60 " "
" \$75 " " (" \$4,000 " ")	" \$4.75 " "
" \$100 " " (" \$5,000 " ")	" \$6.00 " "
" \$150 " " (" \$8,000 " ")	" \$9.50 " "
" \$200 " " (" \$10,000 " ")	" \$12.00 " "
" \$400 " " (" \$20,000 " ")	" \$24.00 " "

Note: For single persons, the payment would be about 60% less than listed above - but in no case would a single person's payments be lower than 60% a month.

ATTITUDES ON PLAN TWO

Question: On the list of payments, please find the amount you would pay under this Plan Two, according to your family's present income. (Pause) For this plan, would you be willing to pay the amount listed for your family's income?

Response:

Yes.....	60.3 per cent
No.....	31.5
Don't know.....	8.2
No information.....	<u>0.0</u>
Total	100.0

Question: If you were voting, in a State election, on whether or not this Plan Two (alone) should be put into effect in this State, would you vote for it or against it?

Response:

For.....	55.2 per cent
Against.....	31.1
Undecided.....	13.6
No information.....	<u>0.1</u>
Total	100.0

PLAN THREE CARD

PLAN THREE would provide:

All the services provided by Plans One and Two and also:

Payment of all doctor's bills for having a baby, including care both before and after the baby is born - at home, at the doctor's office, or in hospital. Payment of bills for surgical services and operations for everybody, including surgical care before and after operations - at home, at the doctor's office, or in the hospital.

LIST OF PAYMENTS UNDER PLAN THREE

IF YOUR FAMILY INCOME IS:

THEN YOUR FAMILY'S INSURANCE PAYMENTS
WOULD BE AT THE RATE OF (See Note below regarding single persons):

About	\$10 a week (about \$500 a year)	About	\$1.25 a month
"	\$20 " " (" \$1,000 " ")	"	\$1.75 " "
"	\$40 " " (" \$2,000 " ")	"	\$3.45 " "
"	\$60 " " (" \$3,000 " ")	"	\$5.20 " "
"	\$75 " " (" \$4,000 " ")	"	\$6.90 " "
"	\$100 " " (" \$5,000 " ")	"	\$8.65 " "
"	\$150 " " (" \$8,000 " ")	"	\$13.80 " "
"	\$200 " " (" \$10,000 " ")	"	\$17.25 " "
"	\$400 " " (" \$20,000 " ")	"	\$34.50 " "

Note: For single persons, the payment would be about 60% less than listed above - but in no case would a single person's payments be lower than 60% a month.

ATTITUDES ON PLAN THREE

Question On the list of payments, please find the amount you would pay under this Plan Three, according to your family's present income. (Pause) For this plan, would you be willing to pay the amount listed for your family's income?

Response:

Yes.....	49.5 per cent
No.....	41.0
Don't know.....	9.4
No information.....	.*
Total	100.0

*Less than 0.1 per cent.

Question: If you were voting, in a State election, on whether or not this Plan Three (alone) should be put into effect in the State, would you vote for it or against it?

Response:

For.....	47.0 per cent
Against.....	37.3
Undecided.....	15.6
No information.....	.*
Total	100.0

*Less than 0.1 per cent.

PLAN FOUR CARD

PLAN FOUR would provide:

All the services provided by Plans One, Two and Three, and also:
 Payment of all doctor's bills for everybody; for all kinds of doctors services, including operations - at home, at the doctor's office, or in the hospital.

LIST OF PAYMENTS UNDER PLAN FOUR

IF YOUR FAMILY INCOME IS:

THEN YOUR FAMILY'S INSURANCE PAYMENTS
 WOULD BE AT THE RATE OF (See Note below regarding single persons):

About \$10 a week (about \$500 a year)	About \$1.45 a month
" \$20 " " (" \$1,000 " ")	" \$2.90 " "
" \$40 " " (" \$2,000 " ")	" \$5.80 " "
" \$60 " " (" \$3,000 " ")	" \$8.70 " "
" \$75 " " (" \$4,000 " ")	" \$11.60 " "
" \$100 " " (" \$5,000 " ")	" \$14.50 " "
" \$150 " " (" \$8,000 " ")	" \$23.15 " "
" \$200 " " (" \$10,000 " ")	" \$28.95 " "
" \$400 " " (" \$20,000 " ")	" \$57.90 " "

Note: For single persons, the payment would be about 60¢ less than listed above - but in no case would a single person's payments be lower than 60¢ a month.

ATTITUDES ON PLAN FOUR

Question: On the list of payments, please find the amount you would pay under this Plan Four, according to your family's present income. (Pause) For this plan, would you be willing to pay the amount listed for your family's income?

Response:

Yes.....	36.7 per cent
No.....	52.8
Don't know.....	10.4
No information.....	<u>0.1</u>
Total	100.0

Question: If you were voting, in a State election, on whether or not this Plan Four(alone) should be put into effect in this State, would you vote for it or against it?

Response:

For.....	37.7 per cent
Against.....	46.9
Undecided.....	15.2
No information.....	<u>0.2</u>
Total	100.0

CHOICE OF ALTERNATIVE PLANS

(Do not ask this if one plan (just one plan) has been favored in the previous questions. Ask all others, including those opposing or undecided on all plans. Show ALL four plan cards together).

Question: If one of these four plans were put into effect in this State, which one of them would you prefer?

Response:

	Those who had favored more than a single plan (62.6 per cent)	Those who were opposed or undecided on all plans (18.6 per cent*)
Plan One	3.7	0.6
Plan Two	15.4	0.4
Plan Three	15.9	0.3
Plan Four	23.7	1.0
Undecided and no opinion	3.9	16.3

*Note: Includes 1.1 per cent who resisted classification as opposing all plans.

REASONS FOR OPPOSITION

(Ask only if no plan has been favored in answers to questions relating to specifications. The preceding question is not concerned here.)

Question: What are your main reasons for opposing all the plans presented?

Response:

The plans are too expensive.....	24.4 per cent
I am against government control.....	36.3
I don't believe in them.....	6.5
I would not benefit from them.....	4.3
My present insurance is adequate.....	3.2
The quality of medical care would suffer.....	2.7
Everyone should be self-reliant.....	4.5
Other reasons.....	5.4
Don't know.....	<u>12.7</u>
	100.0*

*100 per cent equals 17.5 per cent of respondents, i.e. those who did not favor any plan.

PART 2MEDICAL CARE AND MEDICAL INSURANCE - STUDIES CONDUCTED FOR THE COMMISSION
BY THE DIRECTOR OF STUDY

INTRODUCTION

From earliest times New York State has been among the foremost States in providing for health and welfare, and has adopted many progressive measures to protect community health and to afford a degree of security against the financial vicissitudes of old age, unemployment and similar personal misfortunes.

In the health field, the virtual conquest of the communicable diseases controllable by sanitation and other methods applicable to the community as a whole has focussed attention on the health and medical services required by individuals as such. Medical science has discovered many new and valuable methods for the prevention, care and mitigation of disease, and these have been accompanied by a progressive increase in the cost of medical care.

Because the need for and cost of medical services for individuals often fall heavily and unpredictably, persons and families of average or above-average means have not infrequently found themselves seriously inconvenienced by unexpected medical expenses. However, the application of the "magic of averages" through insurance has provided many of them with a means of protection against the uneven financial impact of certain medical expenses. The great popularity of hospitalization insurance plans clearly indicates the desire and need for this type of protection.

At the same time, many self-supporting persons and families of below-average means have found that they must often go without necessary medical care unless they choose to seek public or private charitable assistance. The fact that the Legislature had defined a need for more adequate medical care for this group despite a growth in public medical services prompted the Commission to study such public services. The added fact that the private purchase of hospitalization insurance has increased markedly, although it is relatively more easy to obtain hospitalization than to obtain other types of medical care at public expense, suggested that, within the limits of their financial ability, people prefer privately-purchased over publicly-provided medical care. Accordingly, medical and hospitalization insurance were studied with a view to the possibility of enabling persons of less-than-average financial means to purchase such insurance.

The studies conducted for the Commission have therefore dealt with the

costs and patterns of private and public medical care as they exist today, and with the principles and details of voluntary and compulsory medical insurance. The data presented are of a practical nature and relate chiefly to New York State, limitations imposed by time and other factors having made it impossible to cover all phases of the enormous subject of medical care. The critical analyses and interpretations which are inseparable from an adequate presentation of data have been made as objective as is possible. It is hoped that, within the limitations indicated, the data presented in this part of the report will prove of assistance to those who may wish to propose definite action in the field of public medical care or medical insurance.

CHAPTER ITHE COMMISSION ON MEDICAL CARECreation of the Commission and Definition of Its Scope

In his annual message to the Legislature in 1944, Governor Thomas E. Dewey stated:

Medical care for persons who cannot provide it for themselves and their families continues to be one of the chief areas of unmet human need. This calls for cooperative action on the part of public administrators and private physicians to bring about a high order of medical care for the needy sick by the judicious use of tax funds and medical facilities. Our own State-sponsored program of public medical care, operating through local welfare departments, has made great strides in this direction.

New York State's medical care program comprises a partnership of government and the medical profession, functioning cooperatively in the interest of public health and welfare, without endangering medical standards, threatening the professional interest of the practitioner or the financial capacity of our people.

The program is not a solution for all the weaknesses, flaws and defects of public and private medical services. It does have within it the elements of a pattern of adequate care, acceptable to the medical profession and local communities with benefit to the patient, the doctor, the community and the taxpayer.

I have spent many hours in the past year, conferring with leaders in the field of medical care, searching for the solution which will broaden the availability of medicine and hospitals and at the same time will preserve the integrity and freedom of the medical profession. I believe the problem can and must be solved. There is strong will to meet the needs of our people. There is an equally great need. The two must be brought together.

In the field of medical care, I believe the State has an essential function. That we may soundly and promptly meet the need, I respectfully recommend the creation of a commission to propose a program at your next session.

In enacting Chapter 387 of the Laws of 1944 creating the Commission, the Legislature declared that:

.....the health of the inhabitants of the state is a matter of state concern; that medical care for persons who cannot provide it for themselves and their families continues to be one of the chief areas of unmet need; that this calls for cooperative action on the part of public administrators and private physicians to bring about a high order of medical care for the needy sick by the judicious use of tax funds and medical facilities, and that studies, surveys and investigations to that end and the formulation of legislative proposals thereon are in the public interest.

The Commission was to consist of two Senators, two Assemblymen, four physicians, two laymen, one hospital administrator, one bedside registered nurse, one hospital nurse, one public health nurse, and the Commissioners of Health, Social Welfare and Mental Hygiene, ex-officio. A report was to be made to the Legislature on or before February 15, 1945, including draft

legislation necessary to carry its recommendations into effect.

One of the first concerns of the persons originally appointed to the Commission was its scope, the term "needy sick" being considered susceptible of more than one interpretation. On September 5, 1944, in announcing the appointment of members of the Commission, Governor Dewey had said:

The purposes of the Commission are to make necessary studies, in order to devise programs for medical care for persons for all groups and classes in the State of New York.

However, some of the appointees thought that the term "medically needy" as employed in the Governor's message and Chapter 387 might be construed as limiting the scope of the Commission's interest to persons in receipt of or eligible for public assistance, and the Chairman requested guidance from the Governor who on September 30, 1944, replied through his Counsel, Charles D. Breitel, that "the people he (the Governor) had in mind were the middle classes who are not receiving adequate care and that he was not limiting his interest to the indigent sick." With the assurance that its scope embraced the medical needs of the people of the State as a whole, the Commission met on October 25, 1944, and entered upon its duties.

Membership of the Commission

A study staff was selected early in November of 1944, and the Commission at once began its studies and deliberations, but because the time remaining before its report to the Legislature was due was obviously too short to do justice to so enormously complex a problem as medical care, the Legislature early in 1945 enacted Chapter 5 of the Laws of 1945 constituting the Commission for another year and adding to its membership. The addition consisted of two physicians, and seems to have been made in response to protests of the Medical Society of the State of New York that physicians were inadequately represented. The membership of the Commission follows:

Basil G. MacLean, M. D., Rochester; Chairman. Hospital administrator member. Director, Strong Memorial Hospital; Past-President, American Hospital Association; former Vice-President, New York State Hospital Association; Professor of Hospital Administration, University of Rochester; Consultant to Secretary, U. S. Navy; member, Advisory Board on Health Services, American Red Cross, and Chairman of Division of Hospital Administration; member, Presidential Committee on Government Medical Service; Lt.-Colonel, M.C., A.U.S., inactive; Consultant, United States Public Health Service; Consultant, Children's Bureau, U.S. Department of Labor.

Hon. Lee B. Mailler, Cornwall; Vice Chairman. Assembly member. Superintendent, The Cornwall Hospital; member of Assembly, 1934-45; Chairman, New York State Health Preparedness Commission; Vice-President, New York State Hospital Association; Chief of Emergency Medical Service, New York State; member of Moreland Commission, 1943-44; advisor to Joint Hospital Board, New York State Post-War Public Works Planning Commission; special consultant, U. S. Public Health Service.

Very Rev. John J. Bingham, New York. Lay member. Director, Division of Health, Catholic Charities of the Archdiocese of New York; Past-President, New York State Hospital Association; former Vice-President, American Hospital Association; Vice-President, Catholic Hospital Association; Vice-Chairman, Hospital Council of Greater New York; trustee, United Hospital Fund.

Harold R. Brown, M. D., Buffalo. Physician member. 1/ Practicing physician; Past-President, Erie County Medical Society; trustee, Western New York Medical Plan, Inc., trustee, Hospital Service Corporation of Western New York, Inc., Associate in Medicine, part-time, University of Buffalo.

Lucien Brown, M. D., New York. Physician member. Practicing physician; attending Physician, Sydenham Hospital; Vice-Chairman, Greater New York Urban League; member, City-Wide Citizens' Committee on Harlem.

Hon. James A. Concoran, New York (Kings). Senate member. 2/ Real estate broker, member of State Assembly 1940-43; member of Senate, 1943-46; member, Senate Public Health Committee.

Andrew A. Egerton, M. D., Mount Vernon. 1/ Physician member. Practicing physician; Director of Mount Vernon Hospital Laboratory; Director of Laboratories, Manhattan Eye, Ear and Throat Hospital; Past-President, Westchester County Medical Society; member, Board of Directors, Group Health Cooperative, 1943-45.

Hon. Leonard Feinstein, New York (Manhattan). Assembly member. Attorney; member of Assembly, 1933-46.

Agnes Gelinas, R. N., New York and Saratoga Springs. Hospital nurse. Chairman, Skidmore College Department of Nursing, New York Post-Graduate Medical School and Hospital; member, National Nursing Planning Committee; member, State Nursing Council for War Service; member, Nurse Advisory Council, New York State Department of Education.

Edward S. Godfrey, Jr., M. D. Ex-officio member. State Commissioner of Health; Past-President, American Public Health Association; member, Joint Hospital Board of New York State Post-War Public Works Planning Commission; member, Committee on Medicine and the Changing Order, New York Academy of Medicine.

Ruth Hall, R. N., Buffalo. Bedside nurse member. Past-President, New York State Nurses Association; director, American Nurses Association; Secretary, American Journal of Nursing; member, State Nursing Council for War Service; Chairman, New York State Procurement and Assignment Service for Nurses.

Hon. Frederic E. Hammer, New York (Queens). 3/ Senate member. Attorney; member of Senate, 1945-46; Chairman, Senate Public Health Committee; Director, Rockaways Chamber of Commerce; member, Federal Bar Association of New York, New Jersey and Connecticut.

Robert T. Lansdale. Ex-officio member. State Commissioner of Social Welfare; member, New York State Health Preparedness Commission; member, Special Committee on Social Welfare and Relief, New York State Joint Legislative Committee on Interstate Cooperation; Chairman, Joint Hospital Board of New York State Post-War Public Works Planning Commission.

Robert L. Levy, M. D., New York. Physician member. Practicing physician; Professor of Clinical Medicine, Columbia University; Director, Department of Cardiology and Associate Physician, Presbyterian Hospital; member, Subcommittee on Cardiovascular Diseases, National Research Council.

1/ Appointed June 1945.

2/ Appointed January 1946 to succeed Senator Lazarus Joseph.

3/ Appointed January 1945 to succeed Senator Lester Baum.

Frederick MacCurdy, M. D. Ex-officio member. State Commissioner of Mental Hygiene; Past-President, New York State Hospital Association; former Director of Presbyterian Hospital; member, Joint Hospital Board of New York State Post-War Public Works Planning Commission.

George M. MacKenzie, M. D., Cooperstown. Physician member. Practicing physician; Physician-in-Chief, Mary Imogene Bassett Hospital; Past-President, Sixth District Branch, Medical Society of the State of New York; formerly Associate Professor of Medicine, Columbia University; member, New York State Board of Medical Examiners; Past-President, New York State Association of Public Health Laboratories.

Marion Sheahan, R. N., Albany. Public health nurse member. Director, Division of Public Health Nursing, State Department of Health; President, National Organization for Public Health Nursing; Vice-President, American Public Health Association; member, Advisory Committee on Health and Medical Services, American Red Cross.

Herman G. Weiskotten, M. D., Syracuse. Physician member. Dean, Syracuse University College of Medicine; member, Council on Medical Education and Hospitals, American Medical Association; member, New York State Public Health Council; author of "Medical Education in the United States" and "Medical Care of the Discharged Hospital Patient."

Garrard Winston, New York. Lay member. Attorney; Undersecretary, U. S. Treasury, 1923-27; Treasurer, Roosevelt Hospital; President, New York Trade School.

The membership of the Commission has not included a dentist. The omission is no doubt attributable to the fact that when the Commission was established, and in the early months of its active existence, dental care as a part of a State medical program was not contemplated. As the work of the Commission progressed, the need for including at least limited amounts of dental care in a general medical program became apparent and the omission of a dentist from membership was to some extent rectified by the appointment by the Chairman of an official advisory committee of five dentists.

The statutory composition of the Commission would characterize it as a technical body whose function it was to make objective studies and recommendations. It was clearly designed to represent the interests of the people of the State as a whole, inasmuch as no attempt was made to provide proportional representation of different social, economic and occupational groups which might hold different or even conflicting views on the vital problem of medical care. With the exception of the physicians last appointed, who were understood to have represented the Medical Society of the State of New York, the Commission has represented the people of the State rather than any special interest.

Relationship to State Health Preparedness Commission

As provided by Chapter 367 of the Laws of 1944, the Commission on Medical Care has cooperated with the State Health Preparedness Commission

created by Chapter 682 of the Laws of 1936 (formerly known as the New York State Temporary Commission to Formulate a Long Range Health Program), opportunity for the exchange of information being afforded by Assemblyman Mailler serving as Chairman of the Health Preparedness Commission and as Vice-Chairman of the Commission on Medical Care. By agreement of the respective Commissions, the Health Preparedness Commission was to limit its primary interests to the coordination of existing governmental functions concerned with health and medical care, to the determination of natural regions of the State in respect to suitability for development or integration of facilities therein to the end that each region would contain the services and facilities necessary for a comprehensive health program, and to a study of the needs and facilities for care of the chronically ill. The Commission on Medical Care was to limit its primary interests to a determination of the volume, cost and adequacy of medical services available to the people of the State, the extent to which such services needed to be revised, supplemented or supplanted to provide a high order of medical care, and the means whereby needs should be met.

Relationship to Other State Agencies

The membership of the State Commissioners of Health, Mental Hygiene and Social Welfare on the Commission has insured that their respective departments have been fully apprised of the Commission's activities. In addition, the Health Preparedness Commission, the Joint Legislative Committee on Interstate Cooperation, the Joint Legislative Committee on Industrial and Labor Conditions, the Commission on Municipal Revenues and the Reduction of Real Estate Taxes, the Joint Hospital Advisory Board of the State Post-War Public Works Planning Commission, the State Department of Labor, and the State Department of Taxation and Finance, all of which have been engaged in activities touching upon the development or financing of medical services, were notified of the work of this Commission and its consideration of various plans for medical care.

Objectives

The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine. Constitution of the State of New York, Article XVII.

This obligation of the State is or may be discharged by:

1. Determination of the health status and health needs of the people, and the extent to which these needs are being met by measures currently available.

2. Protection of health through safeguarding the individual from health menaces in his environment which are beyond his individual control, through education of the individual in health protection, and through research in improved methods of disease and accident prevention.
3. Restoration of health through professional education and licensure of personnel and institutions to assure high standards of care, through provision of actual medical, dental, nursing and hospital care for those individuals unable to obtain it through their own resources, through making it possible for greater numbers of persons to obtain care through their own resources by means of insurance against the financial hazards of sickness, and through research in improved methods of diagnosis and treatment of disease.

The general objective of the Commission has been to make it possible for residents of the State to provide for themselves that measure of medical care which is adequate in quality and quantity to ensure a fit and health citizenry. In the past a distinction has often been made between protective measures designed to safeguard the individual or community against being subject to the risk of disease, and restorative measures entailing the cure or palliation of disease that has already occurred. While this distinction remains valid in some instances, it has been increasingly apparent in recent years that often there is no sharp dividing line; in fact, protection against a communicable disease such as tuberculosis may depend very largely upon the application of restorative measures to human sources of infection. Therefore, the studies of the Commission, although concerned primarily with measures for the restoration of health, on occasion have of necessity touched upon the activities of established State agencies engaged in the field of health protection.

The specific objectives of the Commission, which have been limited to health measures of the type applicable to individuals, and which have excluded public sanitation and mass methods for the prevention and control of disease, were:

1. Determination of the volume and cost of care furnished by physicians, dentists, nurses, hospitals, clinics and dispensaries, pursuant to law and through individual and other non-official arrangements.
2. Determination of the extent to which existing plans insure individuals against the costs of sickness, pursuant to law and through individual and other non-official arrangements.
3. Determination of the adequacy of existing preventive and diagnostic services.
4. Consideration of the extent to which, and by what means, existing facilities and services need to be revised, supplemented or supplanted to provide a high order of care for the people of the State.

5. Suggestion of means whereby the general quality of care might be improved.
6. Consideration of means whereby a reduction in the cost of care might be effected through expansion of existing preventive and diagnostic services, through development of new preventive and diagnostic services, and through improved administrative methods.
7. Formulation of legislative proposals to accomplish these objectives and put into effect recommendations arising therefrom.

Methods of Study

In addition to its own studies and investigations the Commission has utilized data which were available through State and other agencies, and has on the whole enjoyed excellent cooperation. Special mention is due the State Departments of Health, of Social Welfare, and of Taxation and Finance, the Departments of Health and of Hospitals of the City of New York, and the Blue Cross hospitalization insurance plans, which contributed largely to studies originated by the study staff of the Commission.

At all stages, experts in the various fields covered by the inquiries have been frequently consulted. Also, a series of conferences on tentative plans for medical insurance were held in September and October 1945, at which time representatives of medicine, dentistry, nursing, hospitals, labor, industry, commerce, agriculture, philanthropy, insurance companies and medical and hospital care plans were invited to express their views for the instruction and guidance of the Commission. The tentative plans for medical insurance which served as a basis of discussion for the conferences were also distributed to civic and professional groups and to Federal and State agencies who had requested an opportunity to study them.

In addition to being consulted through the organized groups just mentioned, the attitude of the general public toward medical insurance was determined by the survey of public opinion described in PART 3. Public hearings to obtain an official expression of opinion from all segments of the public, organized and unorganized, were planned but were not held, owing to inability of the Commission to agree upon material which might be presented as a basis for such hearings.

CHAPTER II

THE NEED FOR MEDICAL CARE

Health Trends

Medical care 1/ is recognized as a necessity of life and for many years New York State and its subdivisions have been responsible for its provision, not only to the destitute but also to persons who are financially able to obtain necessities such as food, shelter and clothing but who are unable to pay for necessary medical care. 2/

Public health, and improved medical and socio-economic conditions have over a period of forty years brought about striking reductions in illnesses and deaths due to communicable diseases, as illustrated in Table 1, and the life expectancy of the individual at birth has been markedly increased as shown in Table 2.

Table 1. Death Rates per 100,000 Population from Important Causes, New York State, 1900-40.3/

Year	Typhoid Fever	Diph- theria	Diarrhea & Enteri- tis under 2 years	Tuber- culosis	Pneu- monia
1900	26.7	45.4	23.8	217.3	216.5
1905	19.1	28.0	21.8	194.9	182.9
1910	15.0	26.6	20.8	178.7	187.2
1915	7.8	17.9	14.5	165.9	173.7
1920	3.5	18.1	10.9	119.5	157.0
1925	3.4	8.6	5.7	87.6	116.8
1930	1.2	2.7	3.5	71.1	102.4
1935	0.5	0.8	2.1	56.9	84.4
1940	0.2	0.1	1.1	46.3	45.4

Table 2. Years of Life Expectancy at Birth, New York State, 1900-40.3/

Year	Male	Female
1900	34.99	36.84
1919	38.15	40.17
1920	41.85	45.02
1930	50.02	52.86
1940	57.42	60.62

The conquest of the communicable diseases has not, however, made sickness a negligible factor. On the contrary, there has been, as shown in Table 3, a steady increase in the number of persons and institutions caring for sickness which indicates an increase in the

number of persons seeking and obtaining care.

1/ The term medical care is employed throughout this report as embracing the services of the medical, dental, nursing and all other professions legally entitled to care for the sick, and the use of hospitals, clinics, dispensaries and similar facilities for the ministration of care to the sick. Wherever reference is intended to a particular service, it will be specifically designated as, for example, physicians' services, or hospital care.

2/ Social Welfare Law, Section 184.

3/ Data from Sixty-second Annual Report, New York State Department of Health, 1941, Vol.2

Table 3. Physicians and General Hospitals in New York State, 1899-1941.

Year	Physicians		General hospitals ^{5/}		
	Number ^{4/}	Persons per physician	Number	Beds	Beds per 1,000 persons
1899	9,199	778	-	-	-
1905	11,746	700	-	-	-
1910	13,474	678	-	-	-
1915	14,156	700	-	-	-
1920	14,871	706	-	-	-
1925	16,587	700	294	26,546	2.2
1930	19,231	657	320	45,605	3.6
1935	22,015	601	337	53,370	4.0
1940	25,780	537	339	60,314	4.3

Reasons Underlying Increasing Need for Medical Care

The paradox that the more healthy a people becomes the greater its need for medical care resolves itself into reason upon examination of a few of the underlying factors. A greater value has been placed upon human life and welfare, as evidenced by the many laws enacted in the past fifty years to safeguard life and health, and the decreasing fertility of the population illustrated in Table 4 has emphasized the necessity of medical care for preservation of life and maintenance and growth of the population. ^{6/}

Table 4. Ratio of Births to Deaths, New York State, 1900-40. ^{3/}

Year	Ratio	Year	Ratio
1900	1.6	1925	1.6
1905	1.7	1930	1.5
1910	1.6	1935	1.2
1915	1.7	1940	1.3
1920	1.6	1945	1.5

Due to the prevention of premature death, the population has aged, as shown in Figures 1 and 2, and the natural increase of infirmities with advancing age has necessitated more medical care.

Advances in medical science now offer hope for cure or relief of sickness for which there was formerly no remedy. A partial list of the outstanding medical discoveries of recent years includes:

^{4/} From annual numbers of Medical Directory of New York, New Jersey and Connecticut, Medical Society of the State of New York.

^{5/} From annual hospital numbers of Journal of the American Medical Association. These figures do not agree exactly with those employed in later chapters owing to certain minor differences in definition. They are used here because they come from the same source and have the virtue of comparability over a period of time.

^{6/} An increased ratio during the past few years is attributable to unusual wartime conditions and, judging from past experience, will not be sustained.

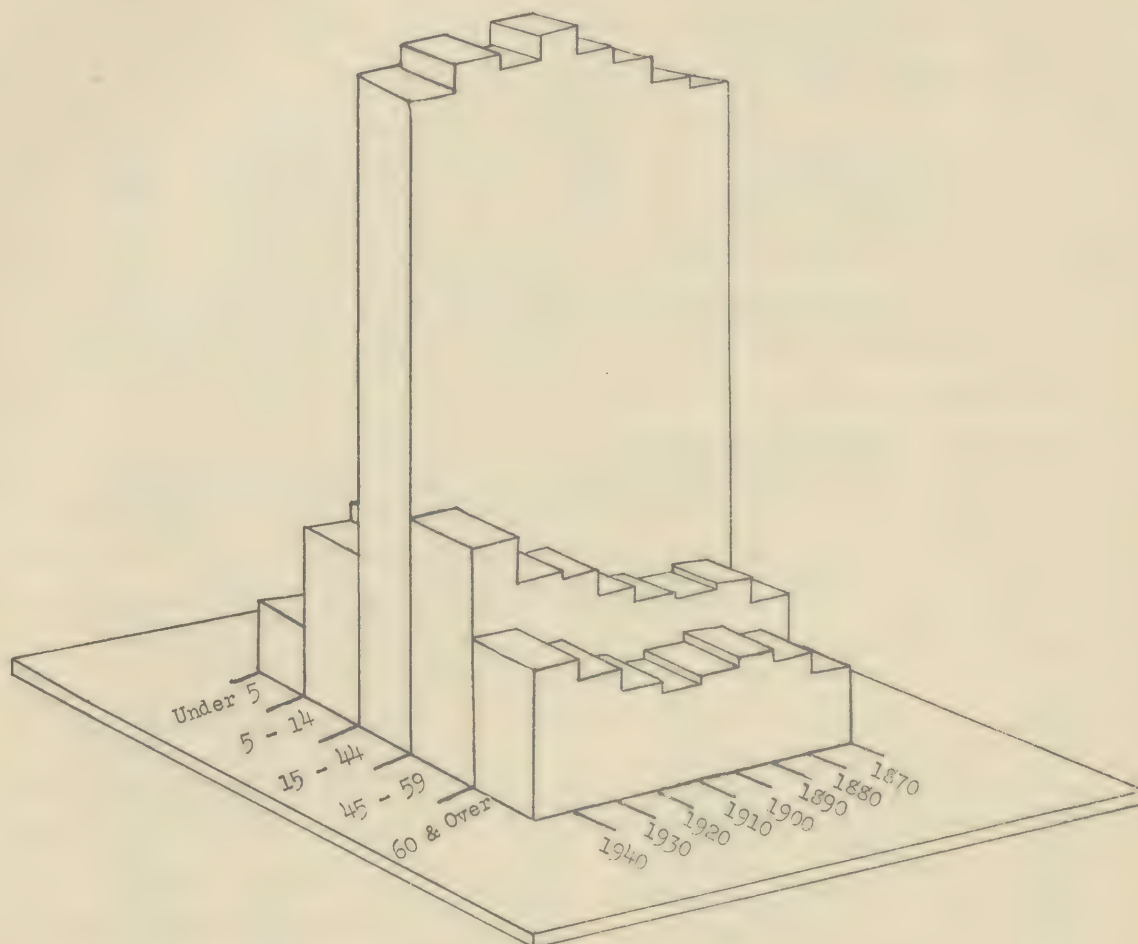


FIGURE 1. THE AGING OF NEW YORK STATE'S POPULATION
 PERCENTAGE OF POPULATION IN EACH AGE GROUP FOR A GIVEN YEAR
 (U. S. Census Figures)

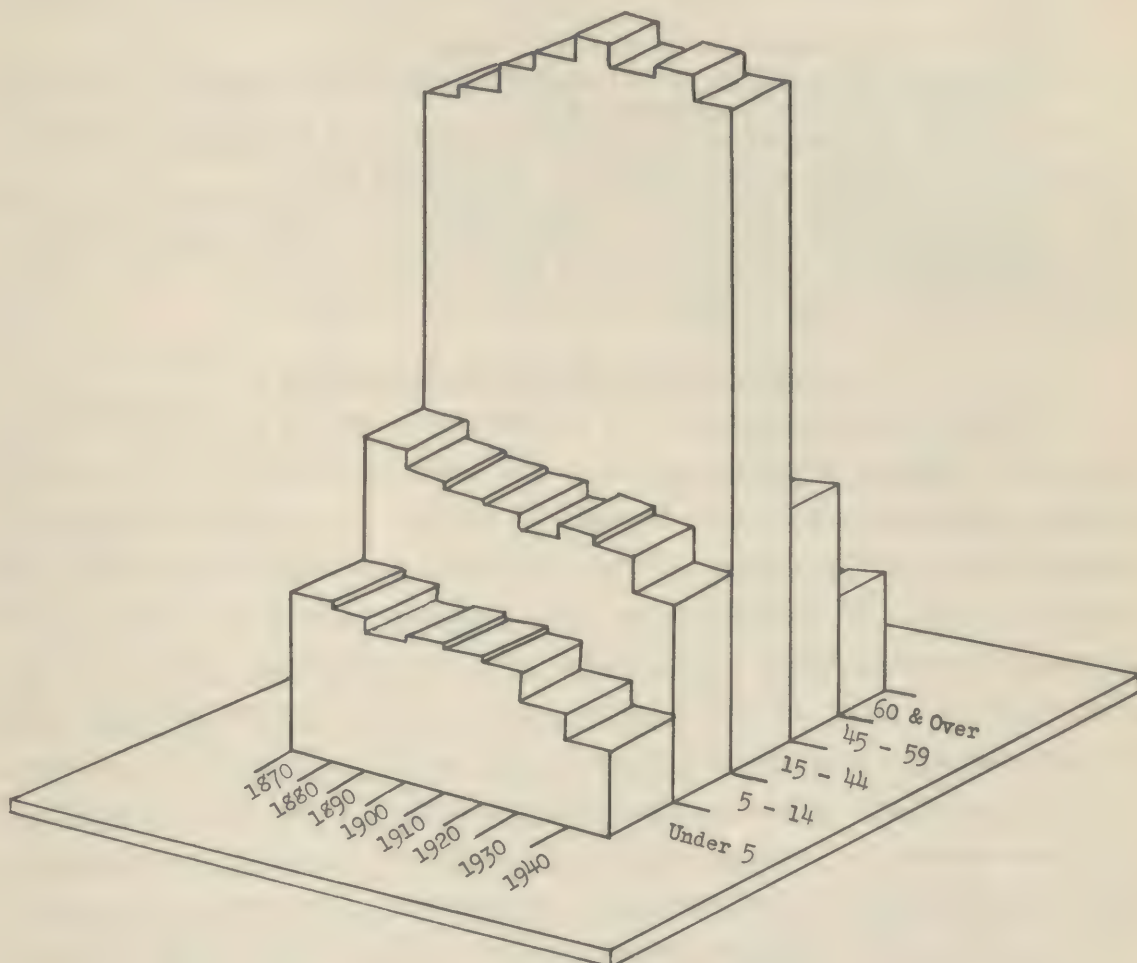


FIGURE 2. THE AGING OF NEW YORK STATE'S POPULATION
PERCENTAGE OF POPULATION IN EACH AGE GROUP FOR A GIVEN YEAR

(U. S. Census Figures)

Insulin for the treatment of diabetes.
 Liver extract for the treatment of pernicious anemia.
 Serums in the treatment of infectious diseases.
 Preventive inoculations against diphtheria, whooping cough and other infectious diseases.
 Development of a host of new or improved diagnostic tests - x-ray, basal metabolism, blood chemistry, bacteriological and serological tests.
 Recognition and treatment of vitamin and other nutritional deficiencies.
 Diagnosis and treatment of allergic conditions.
 Development of surgery in all aspects, especially plastic, thoracic, genitourinary and neurosurgery
 Diagnosis and relief of endocrine imbalance and deficiency.
 Physical therapy - heat, massage, artificial fever.
 Radium and x-ray treatment of cancer and other conditions.
 Arsenicals and heavy metals in the treatment of syphilis.
 Sulfonamides in the treatment of infectious diseases.
 Penicillin in the treatment of infectious diseases.

Current Health Status of the People

Because health departments do not regularly gather data on illness other than communicable disease and a few other conditions such as cancer, it has been necessary to turn to special surveys to determine the general health status of the people. Perhaps the most arresting figures have come from the results of examination of our young men under the national Selective Service Act. Among the first two million selectees, ranging in age from 21 to 36 years, 900,000 were not qualified for general military service because of lack of physical and mental qualifications.^{7/ 8/} It has been estimated that of this number, 200,000 could be made fit for general military service by the application of current restorative procedures. Many of these disabilities might have been prevented by medical care in previous years, but whether preventable or not, they definitely indicate a great prevalence of diseases and disabilities which, for the greater part, require medical care for relief of symptoms. The use of Selective Service figures as an illustration of poor health conditions that could be entirely prevented or cured by medical care is, of course, not justified, nor do the figures indicate complete inability of the affected persons to function in civilian capacities, since the physical requirements for the exacting oc-

^{7/} "Health of Selective Service Registrants," L. G. Rowntree, K. H. McGill and O. H. Folk; Journal of the American Medical Association, 11:1223, Apr. 4, 1942.

^{8/} New York State data are not available on a comparable basis. In New York City, however, up to January 1, 1945 nearly 38 per cent of selectees were rejected for medical reasons only, although standards have been lowered considerably since the early days of Selective Service. Also, many men who would have been rejected by the standards employed earlier have been inducted into military service and have had their defects corrected by the medical services of the armed forces.

cupation of war are not identical with those for civilian life, but the finding of a large number of defects among 18 and 19 year old men who should be at the peak of physical and mental condition indicates that there is a need for medical care at all periods of life. The type and incidence of these defects, without reference to handicap for military service, is shown in Table 5. Among older persons, the incidence of defects is very much greater.

Table 5. Incidence of Defects Among Registrants Examined at Local Boards and Induction Stations.

Disease, or system affected	Cases per 1000	
	White	Negro
Teeth	107	39
Eye	106	38
Musculoskeletal	61	39
Mental	33	35
Cardiovascular	27	46
Ear	27	4
Hernia	25	25
Tuberculosis	8	12
Syphilis	3	127

A more comprehensive picture of the health status of the people is afforded by The National Health Survey, 1935-36.^{9/} Table 6 shows the annual incidence of disabling illness per 1000 persons according to age and broad diagnostic groups. These illnesses, which are exemplified by measles, scarlet fever,

tonsillitis, pneumonia, appendicitis, gastric ulcer, pregnancy, fractured leg, heart disease, asthma, hernia and eczema, kept the persons affected from work, school or other usual activities for a period of 7 days or more and for the greater part were severe enough to warrant medical attention. Although a great and constant need for medical care is evident from the frequency of disabling illness alone, there must be added the vast number

^{9/} National Health Survey, 1935-36, Preliminary Reports, National Institute of Health, United States Public Health Service, Washington, 1938.

Criticisms have been made of The National Health Survey by spokesmen of organized medicine on the ground that it was carried out with the aid of previously untrained personnel under the Works Progress Administration, and that it was conducted at a season and economic period which tended to exaggerate the incidence of disease and its relation to economic status. For example, the President of the American Medical Association has stated: "In 1936 untrained investigators asked people in a house-to-house survey if they had medical care." (New York Times, December 4, 1945.) Many of the findings of the Survey have been utilized in the preparation of this report because they are the most recent figures available or because they present data in a useful form not found in other reports. In view of the criticisms that have been made it does not seem gratuitous to remark that the Survey has been compared carefully with other similar studies and found to be in very close agreement with them. The figures therein seem to be reasonable and conservative estimates of the incidence and prevalence of disease.

Table 6. Number of Cases of Disabling Illness per 1000 Persons per Year, According to Age and Broad Diagnostic Groups 10/

Diagnosis	Age group				All ages
	0-14	15-24	25-64	65 & over	
Infectious diseases	105.4	12.4	5.0	2.3	30.3
Rheumatism	1.1	1.5	7.1	22.8	5.6
Degenerative diseases	3.6	3.4	13.8	80.1	13.4
Nervous diseases	2.4	3.6	6.0	9.3	4.9
Tuberculosis (all forms)	0.4	1.2	1.5	1.0	1.2
Respiratory diseases	49.4	28.0	37.3	57.8	39.8
Digestive diseases	3.6	3.0	9.4	18.7	7.4
Accidents	10.9	13.1	17.2	27.1	15.6
Orthopedic impairments	1.2	1.5	2.8	14.5	2.9
Other diagnoses	46.2	60.4	48.4	41.2	49.6
All illnesses	224.2	128.1	148.5	274.8	170.7

of cases, acute and chronic, which do not disable but which do require medical attention. An example of the latter would be the patient with diabetes who is able to pursue his usual activities, provided he is under medical supervision.

Chronic disease, which affects about one of six persons at any given time, is far from being a problem of old age alone. Its prevalence in the general population mounts steadily with advancing age because many of the chronic diseases are due to degeneration of organs which have served the body well during youth, but many of these diseases, such as allergies, diabetes, arthritis and gastric ulcer, begin early in life. Thus, as indicated in Table 7, 16 per cent of the persons for whom chronic disease or impairment was reported in the National Health Survey were under 25 years of age, 50 per cent were under 45 years and 69 per cent under 55 years of age.

These figures show that there is a great and continuing need for medical care. Although encouraging advances have been made in the absolute prevention of certain illnesses, chiefly those of an infectious nature, and although good medical care may maintain or restore usefulness of the individual and prevent premature death or disability, no method has been or is likely to be found which will prevent the human body from aging, with all of the ensuing ills of the flesh. Additional diseases may prove susceptible of certain prevention, and improved methods of diagnosis and treatment may serve to decrease the volume of medical care in others, but it is predicted that as medical progress is made the successful management of disease will require a volume and cost of medical services greater than

10/ "Disability from Specific Causes in Relation to Economic Status", National Health Survey, 1935-36, Preliminary Reports, National Institute of Health, United States Public Health Service, Washington, 1938.

at present.

Inasmuch as the purpose of this chapter is to ascertain the need for medical care and not the extent to which needs are met, it would seem jus-

Table 7. Persons Reported to Have Chronic Disease or Impairment, According to Age. ^{11/}

Age group	Rate per 1000 population	Per cent of total
Under 5	34.2	1.3
5-14	68.3	6.6
15-24	82.9	8.4
25-34	159.2	15.3
35-44	221.0	19.8
45-54	273.4	18.8
55-64	344.3	14.2
65-74	467.1	10.8
75 & over	513.6 ^{a/}	4.8
All ages	177.0	100.0

a/ Age group 75-84. Rate for age group 85 & over is 602.3

and in villages from 86 per 100 examinations in 1935-36 to 81 in 1941-42.

Table 8 shows the percentages of school children suffering from various

Table 8. Per Cent of School Children with Indicated Type of Defect, New York State, 1941-42. ^{12/}

Type of defect	Per cent of pupils	
	Cities	Villages
Nutritional	5.9	4.6
Dental	45.0	44.0
Visual	8.1	7.3
Tonsillar	7.8	8.2
Cardiac	1.1	1.1
Hernia	.2	.3
Orthopedic	.6	.4
Postural	3.6	2.9
Speech	2.0	.9
Pulmonary	.2	.2
Foot	4.3	2.9

in Delaware County, New York, in 1940. The examinations were conducted and the defects classified somewhat differently than in the school medical inspections (e.g., dental examination was not included). The results of these examinations, which closely approximate those which would be obtained

justifiable to assume that the medical needs of the people of New York State are essentially the same as those of people throughout this nation. Such studies as have been made in this State tend to confirm this assumption. The examination of school children indicates that about 80 per cent of them are suffering from some type of defect.

The rate of defects found in cities has varied from 81 per 100 examinations in 1935-36 to 89 in 1941-42,

types of defects. Comparable studies of adults are not available, except for selectees, but reports of the findings on industrial and other pre-employment examinations show that New York State residents are no less likely to suffer from physical disability than persons of the same color and age in other parts of the country.

Further information on this subject is afforded by the results of examination of 4-H Club members

^{11/} "The Magnitude of the Chronic Disease Problem in the United States" *ibid.*

^{12/} Adapted from Annual Report, State Department of Education, 1941-42, Volume I.

if a child were examined by a private physician in his office, are interpreted as showing an even greater need for medical care than the results of the school medical inspections.

Table 9. Number and Percentage of Individuals
Among 1,047 4-H Club Members Having Indicated
Physical Defect, Delaware County, New York,
1940. 13/

Type of defect	Number	Per cent
Orthopedic		
Foot and posture ^{a/}	671	65.3
Other ^{b/} orthopedic ^{a/}	86	8.4
Visual	346	34.4
Auditory	154	14.7
Cardiac		
Cardiovalvular	7	0.7
Undetermined	43	4.1
Enlarged thyroid	38	3.6
Endocrine imbalance	4	0.4
Phimosis ^{c/}	41	10.5
Indirect inguinal hernia ^{c/}	4	1.2
Undescended testicle ^{c/}	11	2.8
Hypospadias ^{c/}	1	0.3
Miscellaneous	755	72.1

a/ Based on 1,028 members receiving orthopedic examinations.

b/ Based on 1,006 members receiving eye examinations.

c/ Based on 391 males examined for such.

CHAPTER III

THE ECONOMIC ASPECTS OF MEDICAL CARE

Purpose and Scope of Study

Fulfillment of the general objective of the Commission, to make it possible for all residents of the State to provide themselves that measure of medical care which is adequate in quality and quantity, might be expected to aid materially in the accomplishment of two of man's major aims, a happy and comfortable existence, and the avoidance of poverty and financial dependence. There can be no disagreement that adequate medical care would contribute largely to the first of these aims even if it numbered among its many accomplishments only the relief of pain. One of the purposes of this study has been to examine the relationship between economic status and the adequacy of medical care received. Complete agreement does not exist, however, on the role of adequate medical care in preventing poverty and financial dependence. It is obvious to all that illness of a wage earner will often result in time lost from gainful employment, with a consequent reduction in income. It does not seem to be equally obvious that a low income will usually result in reduced ability to obtain medical care, nor that the receipt of medical services by individuals (as contrasted with the receipt of public health services for prevention of disease through immunization, sanitation, etc.) will serve to curtail the severity of illness and prevent disabilities to the extent that the hazards of poverty and financial dependence will be significantly reduced.^{1/} In view of the contention by some eminent members of the medical and public health professions that the people are now receiving all of the medical attention that is necessary, this question has been studied with care.^{2/}

The relationship of economic status to need for and receipt of medical care has been covered thoroughly by many local and national studies conducted by agencies of recognized ability. Only minor differences have been observed in surveys made at different periods, in different areas and

^{1/} "The economic situation of these people is what breeds the need for medical care and all the medical care in the world would not remedy their plight" - "Report of the Planning Committee for Medical Policies, Medical Society of the State of New York," New York State Journal of Medicine, 44: 911, Apr. 15, 1944.

^{2/} For example, "I may remark in passing that it is strange that neither my medical friends nor myself ever come in contact with the cases of medical neglect which are so frequent in the literature of the proponents of compulsory health insurance" - address of the President, California Medical Association, published as "The Philosophical Background of Compulsory Health Insurance," California and Western Medicine, 6:247, May 1943.

by different agencies. The differences found to exist were those of degree rather than kind, and throughout all of the reports there is a definite and constant pattern. Although none of the comprehensive studies of this subject which were consulted related to New York State alone, various communities in this State have been included in many of them and there is no reason to suspect that New York does not correspond roughly to the findings for the country as a whole or with respect to comparable communities. Early in its deliberations the Commission decided that it would not be a wise expenditure of time and money to duplicate studies of this nature, and that sufficient data for its purposes were available in existing publications. Many of the tables in this chapter have been derived from the wealth of data, some previously unpublished, in Medical Care and Costs in Relation to Family Income, a statistical source book by Helen Hollingsworth and Margaret C. Klem,^{3/} although many of the data have been consulted in the original publications, and all have been independently interpreted.

^{3/} Issued as Bureau Memorandum No. 51, Bureau of Research and Statistics, Social Security Board, Washington, March 1943. The 13 studies from which the authors obtained their data are:

1. Sickness and medical care in rural families in a petroleum area of Arkansas, 1938. University of Arkansas.
2. Illness in families in the Eastern Health District of Baltimore, Md., 1938-39 and 1939-40, U. S. Public Health Service and Milbank Memorial Fund.
3. Medical care and costs in California families in relation to economic status, 1933-34. California Emergency Relief Administration.
4. Incidence of illness and receipt and costs of medical care in families in 130 communities, in a 12-month period, 1928-31. Committee on the Costs of Medical Care.
5. Family spending and saving in wartime in the United States, 1941 and first quarter of 1942. U. S. Bureau of Labor Statistics and U. S. Bureau of Home Economics.
6. Morbidity in families in Hagerstown, Md., 1921-24. U. S. Public Health Service.
7. Relation of sickness to family income and income change in 10 communities, 1933; Health and Depression Studies, U. S. Public Health Service and Milbank Memorial Fund.
8. Costs of medical care in families of field employees of the Metropolitan Life Insurance Company in the United States and Canada, 1930-31. Metropolitan Life Insurance Company.
9. Illness and medical care in families in 83 urban areas, 1935-36; the National Health Survey. U. S. Public Health Service.
10. Family expenditures in the United States, 1935-36. Based on data from the Study of Consumer Purchases. National Resources Committee.
11. Disabling sickness in families in cotton-mill villages of South Carolina, 1916 and 1917. U. S. Public Health Service.
12. Money disbursements of families of wage earners and clerical workers in 42 cities, 1934-36. U. S. Bureau of Labor Statistics.
13. Income and expenditures of families of wage earners and small-salaried employees in 92 localities, 1918-19. U. S. Bureau of Labor Statistics.

Prevalence and Incidence of Illness

Prevalence of illness refers to the number or proportion of persons who are ill at any given time, and is determined by surveys wherein the number of persons ill on the day of interview is recorded, whereas incidence is a record, usually based on interview or questionnaire, of illness that occurred in a preceding period of time. Because of their nature, these two indices should be qualitatively similar. Prevalence is the more accurate index of illness because it is not necessary to depend on the memory of the person questioned, but, being limited with respect to time, it does not lend itself to an analysis of the type and duration of illness, etc. as does incidence, which has been more frequently employed for sickness studies.

Table 1. Persons Disabled ^{a/}
by Illness on Date of Inter-
view, 1935-36 ^{4/}

Income group	Per cent disabled
Relief	6.6
Under \$1,000	4.4
1,000-1,499	3.5
1,500-1,999	2.6
2,000-2,999	3.5
3,000-4,999	3.9
5,000 or more	4.1
All groups	4.2

a/ Inability to work, attend school or pursue other normal activities on account of illness, injury or gross physical impairment resulting from disease or accident.

Prevalence. Although the prevalence of illness varies markedly with season and to some extent from place to place, in all of the reports there is a constant relationship to economic status, Table 1 being but one typical illustration of the association of a high prevalence of illness with low income. This is not a surprising finding in view of the fact that such factors as nutrition, housing, occupation and education, which are largely dependent upon economic status, have a direct relationship to susceptibility to many diseases; in fact, the surprising find-

ing is that above the lowest income levels, there is so little variation in prevalence.

Incidence and severity. Two factors which may tend to oppose each other must be kept in mind in interpreting incidence rates. Illness affecting a wage-earner is likely to be reflected in diminished income, so that in many instances low income is the result rather than the cause of illness. On the other hand, because persons in the higher income groups obtain medical attention more frequently they are more likely to recognize

^{4/} From Table 127, Medical Care and Costs in Relation to Family Income, which was based on unpublished data from The National Health Survey, 1935-36.

and report illnesses which are ignored and forgotten in the low income groups. 5/6/

In accordance with the observation made on prevalence, a high rate

Table 2. Annual Incidence of Disabling Illness per 1,000 Persons, in Relation to Age and Family Income, 1935-36^{7/}

Income group	Under 15	15-24	25-64	65 & over	All ages
Relief	251	172	238	371	237
Under \$1,000	206	149	159	285	178
1,000-1,499	209	121	133	254	156
1,500-1,999	214	106	125	237	146
2,000-2,999	233	95	123	236	146
3,000-4,999	249	94	123	215	145
5,000 or more	271	94	118	237	147
All incomes	224	128	149	275	171

of incidence of illness is found to be associated with low income, as indicated in the column for all ages in Table 2. This is especially noticeable in the relief group and holds for all types of disease. It will be noted, however, that the association does not hold with respect to incidence among the higher

income groups. The association is observed only for family incomes of less than \$3,000 in the age group 15-24, and for family incomes of less than \$2,000 in the age groups 25-64, and 65 and over. If income status had no effect on susceptibility to disease, the incidence rate in the group under 15 years, in which illness would not affect a wage earner and bring about a decrease in family income, would be expected to remain constant. At first glance this seems to be the case because, in the age group under 15, after an initial high rate in the relief group, the incidence of illness mounts steadily as income increases. A study of Table 3 shows that the reason for this behavior lies in the relative frequencies of the various types of disease in respect to age. The respiratory and other acute infectious diseases, which are largely self-limited, constitute about 75 per cent of disabling illnesses in the group under 15 years of age and thus mask the association of low income with high incidence of chronic and degenerative diseases which is evidenced in the under 15 as well as other age groups. In the older age groups, the respiratory and other acute infectious diseases account for only about 30 per cent of dis-

5/ Unpublished studies of the Committee on the Costs of Medical Care (Table 135, Medical Care and Costs in Relation to Family Income).

6/ The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Families, I. S. Falk, Margaret C. Klem and Nathan Sinai, Publication No. 26 of the Committee on the Costs of Medical Care, University of Chicago Press, 1933.

7/ "Disability from Specific Causes in Relation to Economic Status", National Health Survey, 1935-36, Preliminary Reports, National Institute of Health, United States Public Health Service, Washington, 1938.

abling illness and the constant association of low income with high incidence of chronic and degenerative diseases is more apparent. It must be kept in mind that the factor of underreporting in the lower income groups, which has been mentioned previously, tends to depreciate rather than exaggerate this association. It seems quite clear from this analysis, especially in respect to the group under 15 years of age, that low income of itself plays an important role in the development of chronic and degenerative disabling diseases, and that poverty, as exemplified by the relief group, predisposes to a high rate of incidence of the acute as well as the chronic diseases.^{8/}

From the data in Table 3, and from a similar analysis of the duration of disabling illness, disabling disease may be classified into three main groups:

1. Diseases which are not incurred primarily by reason of low income, and which cause disability regardless of income status. This group is made up chiefly of respiratory and other acute communicable diseases.
2. Diseases not incurred primarily by reason of low income, but which cause disability varying according to income status. This group is made up chiefly of diseases associated with the process of aging, such as heart disease, arteriosclerosis, diabetes, cancer, degenerative arthritis, goiter, varicose veins, hernia, gall bladder, kidney and non-venereal genital diseases, and also includes infectious diseases tending to have permanent effects, such as poliomyelitis.

Table 4. Frequency and Severity of Acute and Chronic Illness,^{a/} as Related to Annual Family Income, 1935-36.^{9/}

Family income status	Annual rate of disabling illness per 100 persons			Average days disability per case		
	Acute	Chronic	Total	Acute	Chronic	Total
Relief	16.5	7.1	23.4	27	163	70
Under \$1,000	11.9	5.4	17.4	26	153	27
1,000-1,999	11.7	3.8	15.5	24	127	49
2,000-2,999	11.3	3.7	15.0	25	116	47
3,000 or more	11.1	3.5	14.9	25	103	44
All incomes	12.4	4.8	17.2	26	132	57

a/ Illness disabling for 7 days or more, plus confinements, hospital cases and fatal illness of all durations. Acute illness is of less than 3 months duration. Chronic illness is of 3 months or greater duration and includes gross permanent impairments, for which the rate is 3 per hundred.

8/ The possibility that the rates in the relief group are higher than the rates in the under \$1,000 group is due to better reporting by the relief group because of receipt of more medical care, is largely discounted by another part of the study which showed the relief group to receive fewer physicians' services, although more nursing and hospital service, than the under \$1,000 group; see Footnote 9.

9/ "Illness and Medical Care in Relation to Economic Status" National Health Survey, 1935-36, Preliminary Reports, National Institute of Health, United States Public Health Service, Washington, 1938.

Table 3. Cases of Disabling Illness per 1000 Persons, by Disease Group, Age and Income Group 1/

Diagnosis	Relief	Under \$1000	1000- 1499	1500- 1999	2000- 2999	3000- 4999	5000 or more	All incomes
Under 15 years of age								
Infectious diseases	112.9	97.0	101.9	104.8	109.5	111.1	114.2	105.4
Rheumatism	1.6	1.1	1.0	1.0	1.0	1.1	.5	1.1
Degenerative diseases	4.6	3.1	3.3	3.3	3.5	3.4	4.0	3.6
Nervous diseases	3.6	2.3	2.2	2.1	1.7	1.4	1.5	2.5
Tuberculosis, all forms	.9	.3	.3	.2	.2	.2	.1	.4
Respiratory diseases	44.9	45.1	43.7	45.5	54.1	67.2	80.7	49.4
Digestive diseases	4.8	3.9	2.9	3.2	2.6	2.9	3.3	3.6
Accidents	12.9	10.3	10.6	9.9	9.6	10.7	10.8	10.9
Orthopedic impairments	1.4	1.2	1.2	1.1	.9	.8	.6	1.2
Other diagnoses	77.2	41.5	42.5	43.1	50.1	50.2	55.3	46.2
All diagnoses	250.8	205.8	209.6	214.2	233.2	249.0	271.0	224.3
15-24								
Infectious diseases	16.0	15.2	10.6	10.4	9.8	10.8	11.0	12.4
Rheumatism	2.3	1.6	1.4	1.0	1.0	1.0	2.0	1.5
Degenerative diseases	6.2	3.9	2.6	2.6	2.5	1.6	2.0	3.5
Nervous diseases	5.8	3.9	2.9	3.0	2.8	2.3	1.0	3.6
Tuberculosis, all forms	2.4	1.6	.9	.9	.7	.3	.4	1.2
Respiratory diseases	32.3	30.4	24.9	25.7	25.5	28.6	29.0	28.0
Digestive diseases	4.5	3.4	2.7	2.3	2.2	1.6	2.0	3.0
Accidents	15.4	14.1	12.3	12.1	12.2	11.8	11.0	13.1
Orthopedic impairments	2.4	1.4	1.2	1.4	.9	1.5	2.0	1.5
Other diagnoses	84.0	73.6	61.4	46.3	37.6	34.9	34.0	60.4
All diagnoses	171.9	149.1	120.9	105.7	95.2	94.4	94.4	128.2
25-64								
Infectious diseases	7.7	5.5	4.8	4.1	3.9	4.1	3.8	5.0
Rheumatism	13.8	8.4	5.8	5.3	5.1	4.4	3.8	7.1
Degenerative diseases	25.3	16.3	11.3	10.1	10.2	10.6	11.8	13.8
Nervous diseases	10.5	7.6	5.3	4.2	4.5	4.0	4.2	6.0
Tuberculosis, all forms	4.3	1.8	1.1	.8	.7	.5	.5	1.5
Respiratory diseases	52.1	38.2	32.8	33.0	34.5	39.1	38.7	37.3
Digestive diseases	17.2	10.8	7.9	7.1	7.4	7.0	6.5	9.4
Accidents	24.3	20.3	16.3	14.5	13.9	13.4	12.2	17.2
Orthopedic impairments	5.9	4.1	2.1	1.6	1.7	1.5	1.2	2.8
Other diagnoses	76.4	46.5	46.1	44.1	41.0	38.7	35.3	48.4
All diagnoses	237.5	159.5	133.5	124.8	122.9	123.3	118.0	148.5
65 and over								
Infectious diseases	3.2	2.3	2.2	1.6	1.9	3.0	3.0	2.3
Rheumatism	36.3	24.8	19.7	15.8	18.5	15.0	15.0	22.8
Degenerative diseases	102.4	77.9	74.7	78.0	76.6	66.0	73.0	80.1
Nervous diseases	11.3	11.2	7.4	7.5	7.6	7.0	9.0	9.3
Tuberculosis, all forms	2.0	1.0	.7	.6	.2	.3	.3	.9
Respiratory diseases	73.6	61.1	54.8	49.7	48.6	49.0	49.0	57.8
Digestive diseases	27.7	21.3	15.6	13.2	13.6	15.0	16.0	18.7
Accidents	32.8	28.4	26.4	23.5	24.6	23.0	23.0	27.1
Orthopedic impairments	24.2	15.3	13.0	10.4	10.7	9.0	7.0	14.5
Other diagnoses	57.8	41.1	39.5	36.3	33.7	28.0	42.0	41.2
All diagnoses	371.3	284.4	254.0	236.6	236.0	215.3	237.3	274.7
All ages								
Infectious diseases	45.3	27.3	29.4	27.4	25.9	23.8	22.3	30.3
Rheumatism	8.6	7.1	4.5	4.1	4.2	3.8	3.7	5.6
Degenerative diseases	18.6	16.7	11.0	10.4	10.8	10.9	13.4	13.4
Nervous diseases	7.3	6.1	4.2	3.7	3.8	3.4	3.7	4.9
Tuberculosis, all forms	2.7	1.4	.8	.7	.6	.4	.4	1.2
Respiratory diseases	50.6	40.4	35.2	35.3	37.5	42.6	44.5	39.8
Digestive diseases	11.1	8.9	6.2	5.7	5.8	5.7	6.0	7.4
Accidents	19.1	17.7	14.7	13.5	13.3	13.2	12.6	15.6
Orthopedic impairments	4.7	4.0	2.2	1.9	1.8	1.8	1.6	2.9
Other diagnoses	68.9	49.7	47.6	43.9	41.9	39.4	38.7	50.0
All diagnoses	236.9	179.3	155.8	146.6	145.6	145.0	146.9	171.1

1/ "Disability from Specific Causes in Relation to Economic Status", National Health Survey, 1935-36, Preliminary Reports, National Institute of Health, United States Public Health Service, Washington, 1938.

3. Diseases incurred primarily by reason of low income, but which cause disability varying according to income status. In this group are found such chronic communicable diseases as tuberculosis and venereal disease (the latter was not enumerated in The National Health Survey). Other conditions such as accidental injuries and orthopedic impairments, which reflect the more arduous or hazardous occupations of the lower income groups are also represented.

The argument that medical care plays no role in preventing disease is refuted by the outstanding examples of tuberculosis and venereal disease.^{10/}

Table 5. Proportion of Family Heads Reported as Not Seeking Work Because of Chronic Disability, 1935-36.^{9/}

Family income status	Number of family heads	Not seeking work because of disability	
		Number	Per cent
Relief	88,090	4,616	5.2
Under \$1,000	157,177	3,738	2.4
1,000-1,999	209,088	1,721	0.8
2,000-2,999	60,134	308	0.5
3,000 or more	31,792	138	0.4
All incomes	546,281	10,521	1.9

The importance of medical care in reducing disability from diseases which are largely unpreventable is illustrated by its achievements in restoring useful activity to persons suffering from diabetes, pernicious

anemia, chronic heart disease, accidental injury and chronic disease of the genito-urinary tract.

Another approach to this problem emphasized the financial dependence which may result from chronic disease. The data in Table 4 are interpreted as showing that although the average duration of the acute disabling diseases is nearly a month, they do not bring about the reduction of income that is produced by the disabling chronic diseases which have an average duration of 4 to 5 months and which affect approximately one out of every 20 persons in the course of a year. Probably more than half of this chronic disease affects persons in the productive ages between 24 and 55 years.^{11/}

Excluding family heads who were housewives, students or persons retired or at home for reasons other than disability, nearly one out of fifty family heads was reported in 1935-36 as not seeking work because of chronic disability, as shown in Table 5. With the incentive of high wages or under patriotic stimulus workers may, as during the recent war effort, seek employment and be accepted despite conditions which would ordinarily

^{10/} It is of interest that these diseases, unlike the majority of others in the traditional field of public health, are fought chiefly by the application of medical care rather than the usual public health methods of sanitation, isolation and specific immunization.

^{11/} Estimated from Table 7 of Chapter II, which, however, includes all chronic disease, disabling and non-disabling.

be considered disabling. In more nearly normal times, however, the chronically disabled constitute a financial burden on the whole population. The expansion of Federal and State vocational rehabilitation programs,^{12/} especially in the field of medical rehabilitation, gives testimony to public awareness of the need for providing medical care at public expense for the sound economic and social purpose of assisting people to become self-supporting, as well as for the charitable purpose of relieving physical discomfort.

Receipt of Medical Services

It is generally known that the lower the income, the fewer the medical services received. There is no fixed standard according to which the services received may be judged as to adequacy. In subsequent chapters devoted to estimates of the cost of adequate medical care there has been used the definition of Lee and Jones:^{13/}

Adequate medical care has both a quantitative and a qualitative aspect. It means a sufficient quantity of good medical care to supply the needs of the people according to the standards of good current practice.

It is implied in this definition that the standard is a shifting one, dependent upon current practice rather than a rigid formula.

The data cited below were collected about 15 years ago and in the meantime medical practices have changed somewhat, yet there is no reason to suspect their validity in a relative sense, although they suffer in that they offer no expression of adequacy as respects quality. As to quantity of medical services, Lee, now president of the American Medical Association, has called attention to "luxury medicine", and has opined that a substantial majority of patients like more attention than is adequate, and are often willing to pay for it.^{14/}

On the other hand, as shown in Table 6, in 1928-31 not even the highest income groups came up to the standards established by Lee and Jones at that time. It therefore seems both reasonable and conservative for the purpose of interpreting the data which follow, to assume as a standard the volume of service received by persons in the family income group of \$5,000-9,999, or \$5,000 or more.

^{12/} Descriptions of New York State's Vocational Rehabilitation Program under the State Department of Education, and the medical rehabilitation program under the State Department of Health, are given in subsequent chapters.

^{13/} The Fundamentals of Good Medical Care, R. I. Lee and L. W. Jones. Publication No. 22 of the Committee on the Costs of Medical Care, University of Chicago Press, 1933.

^{14/} "Adequate Medical Care", R. I. Lee, Journal of the American Medical Association, 129:989, December 9, 1945.

Table 6. Services Received in Income Group \$5,000-9,999 or \$5,000 or More Compared with Services Required by Lee - Jones Standard of Adequacy, 1928-31.

Type of service	Services per person	
	Required ^{a/}	Received ^{b/}
Days of general hospital care	1.07	.88
Home and office calls for illness	5.65	4.35
Physical examinations	.71	.14
Child health supervision (under 5 years)	3.6	.21
Refractions or glasses	.17	.10
Dental services	6.74	1.88

a/ See Footnote 13.

b/ Representative data selected from Table 7.

Table 7 shows that with the single exception of hospital care the lower income groups receive considerably fewer services than do the higher income groups, although the need of the lower income groups has been previously shown to be greater. With regard to hospital care, the lowest income group receives a relatively large amount of care in terms of hospital days, this being due to long periods of hospitalization rather than frequent hospital admissions. Community welfare and medical services are better organized to provide hospital than other types of care, probably in large measure because the need is more obvious, but aside from the lowest income group, the other low income groups do not fare so well. The least disparity between high and low income groups is in the categories of physicians' and clinic visits, and drugs; the greatest is in special and preventive services such as health examinations, dental care, eye care, x-ray service and physiotherapy.

Expenditures for Medical Services

Data for medical expenditures by economic status, type of service, etc., relate to direct expenditures by the consumer of service and do not include public, philanthropic or other expenditures. As indicated in Table 8, about 80 per cent of all expenditures are made by the consumer.

Consumer outlay^{15/} for medical care varies within wide limits according to national income, but, despite a definite upward trend over the period 1929-42, as shown in Table 9, the proportion of total expenditures which is devoted to medical care is remarkably constant through periods

^{15/} Consumer outlay represents the value of goods or services reaching the consumer. Payments to government are excluded except for payment for postage and other utilities. The expenditures rather than the income of non-profit corporations are included. Savings are omitted.

Table 7. Receipt of Medical Care in Relation to Family Income

Type of service	Under \$1,200	1,200-1,999	2,000-2,999	3,000-4,999	5,000 or more a/	10,000 or more
Medical care received per 100 persons per year b/c/						
Physician, clinic, etc.	45	45	44	49	57	68
Hospital care	10	6	7	7	8	12
Dental care	17	18	23	30	42	54
Eye care and glasses	3	2	3	5	9	14
Health exam & immunizations	6	8	7	10	15	26
Any medical care	58	58	60	67	75	85
Physical examinations per 1,000 persons d/e/						
Under 5 years of age	43	35	58	83	178	-
5-14	110	120	105	120	176	-
15-24	39	32	51	57	117	-
25-44	25	18	28	50	110	-
45-64	9	18	33	42	135	-
65 and over	8	7	42	64	136	-
All ages	52	51	57	71	137	-
Infant and child health supervision per 1,000 persons d/e/						
Under 5 years of age	225	142	130	139	214	-
5-14	15	7	2	3	2	-
Eye refractions per 1,000 persons f/g/						
Under 5 years of age	3	1	5	4	5	-
5-19	30	28	37	50	109	-
20-44	22	23	37	54	84	-
45-64	26	46	68	66	161	-
65 and over	20	18	58	64	74	-
All ages	22	24	36	50	102	-
Dental services per 1,000 persons h/i/						
Fillings	141	289	474	618	997	-
Extractions	234	298	309	312	254	-
Prophylaxis and examination	29	58	98	183	451	-
Crowns and bridges	7	19	32	55	82	-
Plates	7	12	16	13	3	-
X-ray	6	14	24	41	70	-
Orthodontia	1	2	3	5	29	-
General hospital care, days per person j/k/						
Cities of 100,000 or more	1.81	.78	.80	.56	.95	-
Cities of 5,000-99,999	1.13	.55	.58	.55	.88	-
Rural & cities less than 5,000	.70	.53	.51	.59	.50	-
Physicians' office calls per person l/m/						
New York and Chicago	.86	.88	1.09	1.47	1.42	2.31
Other cities 100,000 or more	.97	.92	1.34	1.68	2.36	2.20
Cities 5,000-99,999	1.05	1.08	1.30	1.51	2.23	1.88
Towns of less than 5,000	1.05	1.14	1.36	1.29	2.21	-
Rural areas	.69	1.04	1.13	1.43	.99	-
Physicians' home calls per person 1/m/						
New York and Chicago	1.85	1.20	.79	.91	1.16	1.45
Other cities 100,000 or more	1.09	.82	.98	1.32	1.99	2.83
Cities of 5,000-99,999	.90	1.10	1.18	1.13	1.27	2.24
Towns of less than 5,000	.92	.95	1.00	1.18	.94	-
Rural areas	.46	.53	.65	.85	.46	-
Medical attendance in illness, per 100 cases n/m/						
No days of disabling illness	54	68	72	71	78	83
Less than 3 days disability	53	65	70	69	78	83
Less than 6 " "	54	65	71	71	80	84
Less than 9 " "	56	67	72	72	80	85
Less than 25 " "	60	70	74	75	82	87
All illnesses	63	71	75	76	83	88

Footnotes are at end of table, on following page.

Table 7. cont'd. Receipt of Medical Care in Relation to Family Income

Type of service	Under \$1,200	1,200-1,999	2,000-2,999	3,000-4,999	5,000 or more a/	10,000 or more
Special services in attended illness, per 100 cases o/p/						
Laboratory service	6.6	7.1	7.3	7.8	10.2	-
X-ray service	3.6	3.4	3.4	3.8	6.2	-
Physiotherapy	1.1	1.1	1.4	2.4	3.4	-
Percentage of illnesses treated surgically g/r/						
Otitis media & mastoiditis	16	21	20	24	28	-
Appendicitis	52	46	66	60	75	-
Other diagnoses	1.6	1.9	2.9	2.3	3.2	-
Female genital	17	25	27	22	26	-
Boils and abscesses	12	11	31	10	19	-
Accidents	22	21	19	16	17	-
All illnesses	6.6	7.1	8.4	7.4	8.8	-
Medicines and drugs, per cent of all illnesses s/p/						
On doctor's prescription	36	43	47	46	45	-
On druggist's advice only	4	4	3	3	1	-
Free or clinic care only, per 100 persons t/ m/						
All care free i/	9.1	4.1	2.1	1.2	.9	.3
Physicians' services free	7.0	3.7	2.2	1.9	1.9	1.1
Hospital care free	9.0	4.1	2.1	1.2	.8	.3
Dental care free	3.3	1.6	.7	.5	.8	-
Clinic care only	11.3	6.3	3.2	2.3	3.0	1.2

a/ Income group \$5,000 or more represents the \$5,000-9,999 group where figures for \$10,000 or more group are also entered.

b/ Medical Care and Costs in Relation to Family Income, Helen Hollingsworth and Margaret C. Klem, Bureau Memorandum No. 51, Bureau of Research and Statistics, Social Security Board, Washington, March 1943. (This item, from Table 64, applies only to cities of 100,000 or more.)

c/ The Incidence of Illness and the Receipt and Cost of Medical Care Among Representative Families, I. S. Falk, Margaret C. Klem and Nathan Sinai, Publication No. 26 of the Committee on the Costs of Medical Care, University of Chicago Press, 1933.

d/ From Table 121, of b/.

e/ "Frequency of Health Examinations in 9,000 Families: Based on Nation-Wide Periodic Canvasses, 1928-31", Selwyn D. Collins, Public Health Reports, 49:321, March 9, 1934.

f/ From Table 118, of b/.

g/ "Frequency of Eye Refractions in 9,000 Families; Based on Nation-Wide Periodic Canvasses, 1928-31", Selwyn D. Collins, Public Health Reports, 49:649, June 1, 1934.

h/ From Table 114 of b/.

i/ "Frequency of Dental Services Among 9,000 Families; Based on Nation-Wide Periodic Canvasses, 1928-31", Selwyn D. Collins, Public Health Reports, 54:629, April 21, 1939.

j/ From Table 111 of b/. Does not include clinic visits.

k/ "Variation in Hospitalization With Size of City, Family Income and Other Environmental Factors", Selwyn D. Collins, Public Health Reports, 57:1635, Oct. 30, 1942.

l/ From Table 100 of b/.

m/ Unpublished data of the Committee on the Costs of Medical Care.

n/ From Table 74 of b/.

o/ From Table 85 of b/.

p/ "The Frequency of Doctors' Prescriptions and of Laboratory and Related Services in the Treatment of Illness (1928-31)", Selwyn D. Collins, U. S. Public Health Service. In preparation.

q/ From Tables 81 and 82 of b/.

r/ "Percentage of Illnesses Treated Surgically Among 9,000 Families; Based on Nation-Wide Periodic Canvasses, 1928-31", Selwyn D. Collins, Public Health Reports, 53:1593, Sept. 9, 1938.

s/ From Table 84 of b/.

t/ From Table 68 of b/. Applies only to cities of 100,000 or more.

Table 8. Annual Medical Care Expenditures in the United States, by Source of Funds, According to Three Estimates.

Source of funds	Amount (in millions)			Percentage distribution		
	1936 a/	1935-36 b/	1929 c/	1936 a/	1935-36 b/	1929 c/
Consumer	\$2,561	\$2,205	\$2,886	80	77	79
Government	516	516	509	16	18	14
Philanthropy	60	60	182	2	2	5
Industry	75	75	79	2	3	2
Total	3,212	2,856	3,656	100	100	100

a/ Health Insurance, The Next Step in Social Security, Louis S. Reed, 1937.

b/ Consumer Expenditures in the United States; Estimates for 1935-36, National Resources Committee, 1939. Estimates used for government, philanthropy, and industry represent those prepared by Louis S. Reed.

c/ The Costs of Medical Care, I. S. Falk, C. E. Rorem and Martha Ring, Publication No. 27 of the Committee on the Costs of Medical Care, University of Chicago Press, 1933.

of depression and prosperity. Per capita expenditures behave differently, reflecting the changes in national income. The extent to which medi-

Table 9. Consumer Outlay for Medical Care and for All Purposes, United States, 1929-42.^{16/}

Year	Total outlay (millions)	Medical care		
		Amount (millions)	Per cent of total	Per capita
1929	\$78,949	\$3,003	3.80	\$24.66
1933	46,717	2,024	4.33	16.12
1936	62,654	2,538	4.05	19.82
1939	66,848	2,894	4.33	22.11
1942	89,218	3,887	4.36	29.06

cal services received in periods of low national income decrease in volume is not known, but they probably do not decrease proportionately to per capita outlay, because medi-

cal charges per service may decrease and because public welfare services provide a larger volume of free care in such periods.

A comparison of consumer expenditures for medical care with disbursements for other purposes is shown in Table 10 for the year 1941, which may be considered as relatively normal. Expenditures for medical care are less than those for recreation or alcoholic beverages, and only slightly in excess of the combined amount for tobacco and personal care (largely beauty treatments). It might seem that the individual should be able to adjust his budget to easily manage the costs of medical care. There are, however, several factors which make it impossible for him to do so.

Like sickness itself, the cost of medical care for a person or family is largely unpredictable and falls unevenly. In a given year, 47 per cent of persons will suffer no serious illness, 32 per cent will be sick

^{16/} Based on data from "Consumption Expenditures, 1929-43," W. H. Shaw, Survey of Current Business, June 1944.

Table 10. Consumer Outlay, United States, 1941^{16/}

Item	Amount (millions)	Per cent of total
Food	\$18,975	23.68
Household operation	12,337	15.40
Clothing & accessories	10,341	12.91
Housing	9,664	12.06
Transportation	8,901	11.11
Recreation	4,326	5.40
Alcoholic beverages	4,192	5.23
Medical care	3,574	4.46
Personal business	3,041	3.80
Tobacco	2,128	2.66
Personal care	1,274	1.59
Death expenses	577	.72
Education	509	.63
Other	277	.35
Total	\$80,116	100.00

once, 14 per cent twice, 5 per cent three times, and 2 per cent four or more times.^{6/} Table 11 illustrates the distribution of annual medical charges in middle class families, i.e., with annual incomes of \$2,000 2,999 residing in cities of 5,000 99,999 population. In this representative group, 11 per cent of families incurred charges of \$200 or more, amounting to more than 10 per cent of the family's income for that year.

Table 11. Distribution of Families and Medical Charges. Families with Annual Income of \$2,000 2,999, Residing in Cities of 5,000 99,999 Population, 1928-31.^{17/}

Amount of charge	Per cent of total families	Per cent of total charges
None or free	0.5	
Under \$10	8.6	0.5
10 19	13.0	2.2
20 39	20.0	6.4
40 59	10.4	5.7
60 99	16.9	14.6
100 199	19.7	29.8
200 499	9.0	28.3
500 or more	1.9	12.5
Total	100.0	100.0

2 per cent incurred charges of \$500 or more, representing more than 20 per cent of the family's income. Altogether, 11 per cent of families will be responsible in a given year for 41 per cent of total expenditures. When expenditures exceed \$200 per year, about one-half will go for the expenses of hospitalized illnesses.

Table 12 shows the distribution of payments by item of care and amount of annual family expenditures for medical care.

Families of below average income pay much less for medical care than do those of above average income partly because, as previously shown, they

^{17/} Unpublished data of the Committee on the Costs of Medical Care. From Table 52, Medical Care and Costs in Relation to Family Income, see Footnote 3.

Table 12. Percentage Distribution of Family Charges by Specified Item of Care, for Families of \$2,000-2,999 Annual Income, in Cities of 5,000-99,999 Population, 1928-31.^{18/}

Amount of charge	All charges	Physician ^{a/}	Hospital care ^{b/}	Nursing	Dental care	Eye care & glasses	Medicines & drugs	Non-medical practitioner ^{c/}	Other medical care ^{d/}
Under \$10	100.0	25.9	-	-	13.6	-	60.5	-	-
10-19	100.0	33.2	-	-	12.3	0.8	47.9	1.3	4.5
20-39	100.0	40.1	-	-	20.5	3.8	33.0	2.6	-
40-59	100.0	46.0	0.8	0.5	20.1	4.0	25.7	1.4	1.5
60-99	100.0	44.9	4.1	0.9	22.3	3.5	21.6	2.7	-
100-199	100.0	44.1	10.0	3.2	20.5	3.0	14.9	2.7	1.6
200-499	100.0	48.5	20.5	3.8	11.8	1.1	10.5	2.8	1.0
500 or more	100.0	44.4	21.9	8.1	8.2	0.5	15.0	0.5	1.4

a/ Represents all physicians' services except those of oculists and ophthalmologists, which are included in charges for eye care, and those included in non-itemized charges of hospital care.

b/ Excludes special nursing.

c/ Represents chiropractors, osteopaths, chiropodists, midwives, faith healers, and other non-medical practitioners.

d/ Includes x-rays, laboratory tests, immunizations, and clinic visits not elsewhere classified.

receive a smaller volume of care, and partly because some, if not all charges, have been graded in accordance with ability to pay. Despite the relative inadequacy of care received and the partial adjustment of charges to ability to pay, medical charges consume a larger proportion of the income of the lower income groups than of the higher income groups, as shown in Table 13. Perhaps

Table 13. Distribution of U.S. Families by Income Group and Medical Expenditures

Income group	1935-36 19/				1942 20/	
	Per cent of families		Spent for medical care		Per cent of families	
	Per family	Per cent of income	Per family	Per cent of income	Per family	Per cent of income
Under \$1,000	41.7	\$30	4.9	20.6	\$42	6.8
1,000-1,999	37.4	60	4.3	29.3	68	4.5
2,000-2,999	12.9	97	4.1	20.4	96	3.9
3,000-4,999	5.4	139	3.8	20.1	143	3.7
5,000 or more	2.6	325	2.6	9.6	241	2.4
All incomes	100.0	\$64	3.9	100.0	\$100	3.6

because payment gradients have generally been moved upward as national income has increased, in 1942 the lowest income group found it necessary to spend a greater proportion of total income on medical care than did the corresponding group in 1935-36.

18/ Unpublished data of the Committee on the Costs of Medical Care. From Table 47, Medical Care and Costs in Relation to Family Income, see Footnote 3.

19/ Family Expenditures in the United States; Statistical Tables and Appendixes, National Resources Planning Board, Washington, 1941.

20/ Civilian Spending and Saving, 1941 and 1942, Division of Research, Consumer Income and Demand Branch, Office of Price Administration, March 1, 1943.

Individual and Group Methods of Paying for Medical Care

Individual payment. The most common method of paying for medical care today is payment of the physician, dentist, hospital, etc., as the charges are incurred. In recognition of the equal need for care of families with low incomes, it has long been the practice under this method to adjust rates somewhat according to financial status. An analysis of data from the survey of the Committee on the Costs of Medical Care is presented in Table 14. Persons in the lowest income groups pay only one-eighth to one-half as much for a given service as do those in the highest group. The essential content of the services is no doubt comparable and although a part of the higher charge paid by the higher income groups may be made for intrinsically more expensive services - luxurious hospital accommodations, gold dental work, etc., - much of it must be made to enable physicians and dentists to make lower charges to the lower income groups. This is to some extent also true of hospital service, but public funds and organized philanthropies play a larger role in making possible the lower per diem cost of hospital care for the lower income groups. In other words, the system of charges is so designed that the well-to-do involuntarily pay a part of the cost of care for those financially less fortunate. An injustice or inequity inseparable from this system is that it is the well-to-do sick, rather than the well-to-do group as a whole, who contribute in this fashion to the cost of caring for the lower income groups.

Although the charges per service are lower for the lower income groups, they do not obtain a volume of service comparable to that received by the higher income groups. If by some magic it were possible to maintain the fee gradients shown in Table 14, and the low income groups could receive the same volume of services as the \$5,000-9,999 income group, they would obviously have to spend an even greater share of their income than they do at present (see also Table 16).

The uneven and unpredictable financial burden of severe illness is met in a variety of ways. A survey covering New York State only, which was made by Elmo Roper for Fortune magazine^{21/}, revealed that whereas only 10 per cent of people saved consciously for sickness and emergencies, 27 per cent found it necessary to draw on their savings because of sickness. A report of the California Association of Small Loan Companies quoted in the New York Times of March 2, 1945 indicated that California

^{21/} "Savings - A Survey", Fortune, November 1945.

Table 14. Average Number of Specified Medical Services Received per Person, Expenditures per Person, and Estimated Charge per Service. a/

Type of service	Under \$1,200	\$1,200 -1,999	\$2,000 -2,999	\$3,000 -4,999	\$5,000 -9,999 a/
Number of services per person b/					
Home & office calls c/	2.11	2.35	2.52	2.94	3.84
Physician in hospital d/	.081	.050	.059	.063	.090
Hospital days e/	1.13	.55	.58	.55	.88
Dental services f/	.43	.69	.96	1.23	1.88
Refractions g/	.022	.024	.036	.050	.102
X-ray and laboratory h/	.06	.07	.08	.10	.19
Expenditures per person (dollars) i/					
Home & office calls j/	\$3.73	\$5.49	\$7.99	\$11.50	\$21.74
Physician in hospital j/	.65	.88	1.28	1.39	4.07
Hospital care k/	1.42	1.80	2.50	3.01	8.84
Dental care l/	.43	2.03	3.40	6.13	15.80
Eye care & glasses	.20	.25	.47	.90	1.64
X-ray and laboratory m/	.19	.66	.24	1.56	1.92
Total	\$6.62	\$11.11	\$15.88	\$24.49	\$54.01
Average charge per service (dollars)					
Home or office calls	\$1.77	\$2.34	\$3.17	\$3.91	\$5.66
Physician in hospital	8.02	17.60	21.70	22.06	45.22
Hospital per diem	1.26	3.27	4.31	5.47	10.05
Dental care	1.07	2.90	3.40	5.11	8.32
Eye care & glasses	9.10	10.42	13.06	18.00	16.08
X-ray & laboratory	3.17	9.43	3.00	15.60	10.00

a/ From data in Medical Care and Costs in Relation to Family Income, see Footnote 3. For simplicity, cities of 5,000-99,999 were selected, except as noted. Period covered is 1928-31. Nursing, drugs and medicines, and non-medical practitioners have not been included. Free, part-pay and full-pay services included.

b/ Services per person are for the income group \$5,000 or more, and expenditures are for the group \$1,000-9,999, which tends to make figures in last column somewhat low.

c/ From Table 139 of a/, which is based on unpublished data of the Committee on the Costs of Medical Care. Includes visits for all purposes except eye care, and clinic visits.

d/ Based on hospitalized illness per person, Table 152 of a/, which is from "Variation in Hospitalization With Size of City, Family Income and Other Environmental Factors", Selwyn D. Collins, Public Health Reports, 57:1635, Oct. 31, 1942. Hospitalization of tuberculosis and mental disease excluded.

e/ From Table 111 of a/, which is based on "Variation in Hospitalization With Size of City, Family Income and Other Environmental Factors", Selwyn D. Collins, Public Health Reports, 57:1635, Oct. 31, 1942. Hospitalization of tuberculosis and mental disease excluded.

f/ From Table 114 of a/. Applies to communities of all sizes, which is based on "Frequency of Dental Services Among 9,000 Families; Based on Nation-Wide Periodic Canvasses, 1928-31", Selwyn D. Collins, Public Health Reports 54:629, Apr. 21, 1939.

g/ From Table 118 of a/. Applies to communities of all sizes. Based on "Frequency of Eye Refractions in 9,000 Families; Based on Nation-Wide Periodic Canvasses, 1928-31, Selwyn D. Collins, Public Health Reports, 49:649, June 1, 1934.

h/ Combined from Table 85 of a/, which was based on "The Frequency of Doctors' Prescriptions and of Laboratory and Related Services in the Treatment of Illness, 1928-31", Selwyn D. Collins, United States Public Health Service - in preparation; after adjustment for frequency of illness and percentage of illnesses attended as given in Tables 132 and 74 of a/. Applies to communities of all sizes.

i/ Calculated from Table 20, see a/, which was based on unpublished data of the Committee on the Costs of Medical Care, after correction for persons per family, calculated from Tables 28 and 37 of a/, the respective numbers being 5.13, 4.66, 4.35, 4.48 and 4.25 for the groups in ascending order of income.

j/ Total expenditure for physician was distributed between home & office, and services in hospital, on basis of relation between total expenditure for hospitalized illness and per cent received by physician which, from Table 91 of a/, is 45.8, 49.1, 51.1, 46.1 and 50.1 per cent for the groups in ascending order of income after redistribution with special nursing excluded. Estimated expenditure for physician in hospital was subtracted from total physician charges to give home & office call charges.

k/ Excludes special duty nursing.

l/ Includes cost of dentures, etc.

m/ Excludes expenditures for some services included with hospital bill.

residents borrowed more than 11 million dollars in 1944 to meet medical, hospital and dental bills - more for this than for any other purpose. In New York State, approximately one-third of personal loans are secured to meet medical expenses.^{22/}

The Massachusetts Bankers Association has developed, with the endorsement of the State Medical and Dental Societies, a "Blue Triangle Plan" for post-payment of medical expenses. For bills of \$35 or more, the patient signs a note which the physician or dentist presents to the bank, the discount rate ranging from 4 per cent on a year's note for \$250 to 10 per cent on a year's note for \$60. The notes are guaranteed by the physician or dentist. The plan was developed in the belief that "most people fail to take advantage of the pre-payment medical plans available." The sponsors of the plan believed that the general health situation was not satisfactory to the people and that "government is almost certain to sponsor an extreme form of socialized medicine unless individual initiative provides a satisfactory solution to the problem." The plan was advanced as "another democratic answer to socialized medicine."

Assuming that full advantage has been taken of such grading of fees and rates as is practiced, if current income, savings or loans do not suffice to meet medical expenses and the patient is not able or willing to forego care, resort may be had to private or public assistance agencies.

Private philanthropic agencies. Exact information is not available concerning the volume and cost of medical care furnished by philanthropic agencies in New York State. Many of the gifts made to hospitals and dispensaries are for construction, equipment, etc., which may indirectly reduce the cost of service to the recipient. Precise data are lacking on the amounts given for current expenses, which would tend to reduce directly the cost of service to the recipient. In the year ended June 30, 1943 the United Hospital Fund of New York (City) distributed \$872,000 among 75 member hospitals to be used for dispensary and hospital services.^{23/} In the rest of the State, Community Chests and similar organized philanthropies make substantial gifts to hospitals (often for the purpose of meeting incurred deficits) which are of assistance in providing free and part-pay care.

Where reference is made to services provided through philanthropy, it must be realized that usually the ability of an institution to provide

22/ Personal communication from representative of a large personal loan company.

23/ Sixty-Fourth Year Book, United Hospital Fund of New York, 1943.

free or part-pay care reflects not only gifts and bequests, but such profit as may be made on furnishing care to persons who pay the full charges.^{24/}

Table 15 shows how the profit on care furnished to private and semi-private patients permit hospitals to furnish care at less than cost to low-income

Table 15. Per Diem Income and Cost of Care Furnished by Member Hospitals, United Hospital Fund of New York^{25/}

Type of patient	Average per diem	
	Income	Cost
Private	\$13.25	\$9.25
Semi-private	8.71	7.22
Ward	3.66	6.98

patients. The term philanthropy, as ordinarily applied to medical care thus includes contributions made unwittingly by those who pay charges in excess of the cost of the service they receive.

Relatively little hospital care is given entirely free on the basis

of private philanthropy. In 1943, the hospitals of the State outside of New York City admitted 2 per cent of patients as free patients, and the hospitals of New York City admitted 3.9 per cent as free patients.^{26/}

In the case of clinic visits, the patient is legally required to prove inability to pay for the services of a private physician before he can take advantage of free or part-pay care from philanthropic agencies.^{27/} In 1939, the most recent year for which data are available, about 70 per cent of visits made to clinics in the State outside of New York City were free due to philanthropy,^{28/} which represents an estimated 4 or 5 per cent of all clinic and physicians' visits, and full-pay or part-pay visits made up an additional 2 or 2.5 per cent. 53 per cent of visits to clinics of voluntary hospitals in New York City were free due to philanthropy,^{28/} this number representing perhaps as much as 8 or 10 per cent of all clinic and physicians' visits, and full-pay or part-pay visits made up an additional 8 or 10 per cent.

Approximately one-half of the bedside care provided by visiting nurses is paid for from private philanthropic funds. It is evident, however,

^{24/} The role of organized and unorganized philanthropy in adjusting medical charges to income has been pointed out previously.

^{25/} From "Alcoholism Is a Hospital Problem," M. Hinenburg, Modern Hospital, 63:60, October 1944.

^{26/} Public Social Services in 1944, 78th Annual Report of the New York State Department of Social Welfare.

^{27/} Except in an emergency and, at the discretion of the registrar, patients received for clinical instruction in medical colleges, and cases of communicable disease. "Rules of Special Application to Dispensaries," Rules of the State Board of Social Welfare, New York State Department of Social Welfare, Albany, April 1, 1935.

^{28/} Medical Care in New York State, 1939, Report of the Temporary Legislative Commission to Formulate a Long Range Health Program, Legislative Document (1940) No. 91.

that the great bulk of free or part-pay care received by the lower income groups is paid for from public funds rather than from private philanthropic funds.

Public assistance. The medical services available to the people of New York State from public sources without charge and without reference to ability to pay, include annual medical inspection of school children at a time determined by the authorities, immunization against diphtheria and smallpox at public clinics conducted periodically by the health departments, and in addition, in the State outside of New York City, the care of tuberculosis in county tuberculosis hospitals, and the diagnosis and treatment of venereal disease. Although charges are often made to hospital patients, laboratory service for the diagnosis of the communicable diseases in non-hospitalized patients is usually available without cost and without proof of eligibility other than referral by a physician. Residents of the State outside of New York City may, upon referral by a physician, obtain laboratory service for the diagnosis of cancer, and biologicals for the prevention and treatment of communicable diseases, medical and hospital service in the diagnosis and treatment of cancer^{29/} and, in the rural areas, child health supervision and orthopedic consultant service. In the case of maternity care, and medical care and health supervision of infants under one year of age, the wives and children of members of the armed forces who are in the lower four pay grades qualify without other proof of individual need.

For all other types of medical service, financial need must be established upon investigation by various official agencies - welfare and health departments, and childrens' courts. In New York City, hospital and clinic care are provided chiefly through the City Department of Hospitals. A few other cities provide hospital and sometimes clinic care through health departments, but outside of New York City a majority of services are provided by welfare departments pursuant to the Social Welfare Law:

Section 184. 1. The public welfare district shall be responsible for providing necessary medical care for all persons under its care, and for such persons otherwise able to maintain themselves, who are unable to secure necessary medical care. The determination as to the medical care necessary for any person shall be made with the advice of a physician.

Section 187. 1. A public welfare district shall provide needed care for sick and disabled persons in a hospital maintained by the municipality or in any other hospital visited, inspected and supervised by the board....

^{29/} Limited to services which can be obtained at the State Institute for Malignant Disease operated by the New York State Department of Health at Buffalo.

All types of medical service are thus covered by some legal provision. However, necessary medical care may be narrowly or broadly interpreted as suits the authorizing agent. Dental care and health supervision are infrequently authorized, for example, and in New York City a conspicuous omission is the item of home calls by physicians to needy, non-relief cases, which is not provided by the Departments of Health, Social Welfare or Hospitals.

Under the sections of the Social Welfare Law cited above, anyone who needs medical care may apply to a public welfare agency and submit to an investigation of financial need. The most recent figures available^{30/} are from studies made in the State outside of New York City in 1939^{28/}. Of all applications for assistance in meeting the costs of necessary medical care, about 93 per cent were made by persons already in receipt of public assistance - Home Relief, Veteran Assistance, Old Age Assistance, Aid to Dependent Children, Assistance to the Blind, institutional or foster home care, but not work-relief - and 7 per cent by persons who were otherwise self-supporting, including work-relief (WPA) cases. Even persons on relief were not all accepted as public charges for hospital care received; 12 per cent of relief patients and 15 per cent of work-relief patients were required to pay part or all of the hospital charges.

Of applications made by non-relief cases and decided upon during the one-month study period, 23 per cent were denied. The average monthly family cash income^{31/} was \$53.63 for those accepted, in contrast to \$84.32 for those denied.^{32/} 69 per cent of those denied were considered able to pay from their own resources (savings, personal property, life insurance, etc.) and the remainder by assistance from legally responsible relatives outside of their own household, or by some other means^{33/}. As shown in Table 16, it is the cost of hospitalized illnesses with which otherwise self-supporting families cannot cope and which forces them to apply for care at public expense. The non-hospitalized illnesses are

30/ The repetition of a study similar to the one made in 1939 was approved by the Commission, but at the request of the State Commissioner of Social Welfare it was not carried out.

31/ Family size averaged 4.3 persons for those accepted, 3.9 for those denied. In a small number of cases there were other sources of income such as free rent, board, fuel, light, milk and farm produce.

32/ 53 per cent of the accepted group and 66 per cent of the denied group had monthly budgets higher than the relief budget.

33/ In certain areas the patient is encouraged, although he may not legally be required, to accept a loan from the welfare agency to be repaid at a later date. It is understood that such a loan cannot be collected by legal means.

Table 16. Type of Medical Care Authorized According to Relief Status, State Exclusive of New York City, November 1939^{28/}

Type of Care	Percentage of applicants receiving indicated service	
	Relief	Non-relief
Hospital care, except obstetrical	8.4	67.3
Hospital care, obstetrical	0.7	11.7
General practitioner	45.1	12.3
Clinic care	15.7	2.8
Specialist	2.4	1.3
Other special services by physician	1.5	6.7
Dental care	5.5	1.8
Nursing care	1.8	0.7
Drugs	23.5	2.1
Appliances	6.7	0.9

either of a type that the patient may endure without care (although possibly to his ultimate detriment), or they involve costs which are comparatively small and which families are better able to meet. Economic conditions in relation to diagnosis were examined in that part of the study relating to discharged hospital ward patients, with the finding that hospital bills were assumed as a responsibility of welfare departments in a higher proportion of diseases of long duration than in diseases of short duration. 71 per cent of applications for hospital care of pulmonary tuberculosis were accepted, and 58 per cent of those for cancer, but only 39 per cent of acute appendicitis cases and 37 per cent of maternity cases. In general, public payment of hospital costs was accepted more readily in urban than in rural areas.

Similar detailed studies were not made in New York City, but the eligibility requirements seem to have been less stringent. In 1938-39 the standard for eligibility for hospital care was an income of less than \$142 per month for a family of 4 persons, and in 1944 the corresponding standard was \$191. Families with incomes above these standards might be eligible for part-pay care, the amount of assistance granted depending upon income and duration of hospitalization.

Insurance.^{34/} Insurance or prepayment against the costs of medical and hospital care is a method that is being used on an increasing scale. It is based upon the fact that the average costs of care are predictable when applied to large numbers of people. Both profit and non-profit plans

^{34/} Detailed descriptions of medical and hospitalization insurance plans in New York State are given in subsequent chapters.

are rather widely available in this State. Blue Cross non-profit hospitalization insurance plans blanket the State, and two types of non-profit policies, one covering physicians' services in surgical and obstetrical cases and one covering physicians' services in hospitalized medical cases are, or will shortly be available in areas containing 92 per cent of the State's population. Few insurance plans of any type covering medical services in the home and office are available, the possibility of excessive use of service having made prospective sponsors wary of entering this field.^{35/} With rare and insignificant exceptions, policies of any type do not cover dental care, special nursing, visiting nurse service, drugs and appliances, or anything but a very modest allowance toward diagnostic tests.

Medical insurance plans may be divided into two groups, service plans, in which the fee or rate paid by the plan to physician or hospital for a specified service constitutes the entire amount which either the plan or the patient may be required to pay for that service, and indemnity plans, in which the patient receives a stipulated amount for specified types of illness or needed care, for which he may have to make additional payments to physician or hospital to cover the full cost. The private commercial insurance companies make payments to the patient, but the non-profit plans pay the indemnity to the physician or hospital. Non-profit hospitalization insurance plans are a mixture of service and indemnity, but chiefly the former, and extra charges are usually incurred only for certain diagnostic tests, extraordinary drugs, and private rather than semi-private accommodations. In the early days, insurance against the cost of physicians' services tended to be of the service type and contracts were sold only to those below a certain income level, perhaps \$2,500 for a family. Next, a combination of service contracts for low-income families and indemnity contracts for persons of all incomes tended to be offered, and the present trend seems to be toward indemnity contracts for all.

Hospitalization insurance covers about 12 per cent of the average cost of all types of medical care (about 25 per cent if doctor and hospital charges alone are considered), and medical insurance for surgical and obstetrical service and the care of medical cases in the hospital may cover another 12 per cent. Although these two types of insurance will

^{35/} Medical and Surgical Care, Inc. of Utica and Group Health Cooperative, Inc. of New York City recently discontinued policies of this type, and Western New York Medical Plan, Inc., has restricted benefits and eligibility. United Medical Service of New York City has recently begun a strictly limited experiment in this field.

cover only one-fourth of the total average expenditure for medical care,^{36/} they meet the items of care which are most likely to come without warning and to entail large and immediate costs.

Although medical and hospitalization insurance is said to be "available" to persons in areas where plans are in operation, its availability is limited by two rather important factors. First, because enrollment is voluntary the plans must guard against issuing policies to people who anticipate immediate medical and hospital services more costly than the initial premium. Also, caution must be exercised against enrolling persons who may anticipate no immediate need but who are poor risks because of chronic or underlying illness. The aim of the plans is to obtain a group of subscribers who correspond as closely as possible to the general population or who have an even lower probability of illness. As a result, the great bulk of enrollments must be on a group basis - e.g., not less than 60 per cent in an establishment of 50 employees, or 50 per cent of the inhabitants of a given community, the percentages varying with the type of plan and the total membership. As the hospital service plans have increased in membership on a group enrollment basis, they have found it possible to take on some added risk by issuing individual policies because the risk is diluted in the great reservoir of favorable risks obtained by group enrollment. Either by refusing enrollment or by excluding care of pre-existing disease from benefits, the financial hazard of the less favorable risks is minimized. Thus, coverage by voluntary insurance is difficult to obtain in the case of the self-employed, irregularly employed, employees in small establishments, old persons and those having physical infirmities, this being much more pronounced in the case of medical than of hospitalization insurance.

The second important limitation is with respect to the premium. It has been shown previously that the individually incurred fees of physicians, dentists and, to some extent, hospital charges, are graded in accordance with ability to pay, but this does not seem possible with voluntary medical insurance.^{37/} For the low-income family, the same volume of care received through an insurance plan may be more costly than if purchased on a pay-as-you-go basis.

^{36/} Even comprehensive insurance plans do not propose to cover drugs and appliances, special nursing, complete dental care - i.e., they would cover no more than 50 to 60 per cent of total medical expenditures.

^{37/} The Health Insurance Plan of Greater New York first announced its intention of issuing policies, the annual cost of which would be about 4 per cent of the first \$5,000 of annual income. It has been learned recently, however, that policies will provide for a uniform premium, and that any grading of charges which may be made will be an internal responsibility of the group of subscribers enrolled in such plan.

In Table 17 there are presented calculations which illustrate how costly medical insurance may be, in a relative sense, to low income families. In the table, which covers only physicians', dental, hospital, x-ray and laboratory service and eye care, and omits special nursing, visiting nursing, drugs, appliances, physiotherapy and the services of non-medical practitioners, Column 1 shows the expenditures per family for services in the volume and at the unit costs obtaining in the period 1928-31. As indicated in Column 2, in such circumstances, the lower income groups must devote nearly twice as great a proportion of income to obtain about one-half as much medical care as the higher income groups.

Table 17. Amount and Percentage of Family Income Required for Medical Care Under Various Methods of Payment.

Income class	Graded service at graded fees ^{a/}		Full service at graded fees ^{b/}		Full service on insurance basis ^{c/}	
	Per family	Per cent of income	Per family	Per cent of income	Per family	Per cent of income
Column	(1)	(2)	(3)	(4)	(5)	(6)
Under \$1,000	\$ 26	4.1	\$ 49	7.5	\$102	15.7
1,000-1,999	43	2.9	85	5.7	102	6.8
2,000-2,999	60	2.4	106	4.2	102	4.1
3,000-4,999	91	2.3	133	3.3	102	2.6
5,000 or more	197	2.0	192	2.0	102	1.0
Total	67	2.9	102	4.4	102	4.4

Explanation of table: Families are distributed by income groups in the percentages that obtained in 1942. Family size is taken as 4.0, 3.9, 3.8, 3.7, and 3.6 for the income groups, in ascending order.

a/ Based on services received and cost per service for the respective income groups, as shown in Table 14.

b/ Based on services received by \$5,000-9,999 income group, and cost per service for the respective income groups, as shown in Table 14.

c/ Based on average cost of care as shown in Column 3, exclusive of administration and similar costs.

Column 3 shows the per family expenditures that would be necessary if in each income group a volume of service judged adequate by reason of being equal to that obtained by the \$5,000-9,999 group were obtained, but were paid for at rates graded in relation to financial ability, according to the customary practices of physicians, dentists, hospitals, etc. In these circumstances, the proportion of family income required is even more disproportionate.

Column 5 shows the cost of service in a volume equal to that of the

\$5,000-9,999 group, if obtained on an insurance basis,^{38/} and Column 6 shows the percentage of income that would be required. Insurance presents a distinct financial advantage to those earning more than \$2,500 per year, since they can obtain adequate care at less than the average cost which they are accustomed to pay. For the lower income groups, the percentage of family income required is so great as to be prohibitive.

It appears that voluntary insurance is limited in its usefulness because premiums are not graded according to income. One device that has been adopted to overcome this has been to persuade employers to bear a share, usually one-half of the cost of the insurance. For a voluntary plan which does not embrace all of the people, this seems to be a very satisfactory method, since it results in a slight increase in the cost of the employer's goods or services which is spread out among all consumers, insured and otherwise. If, however, a voluntary plan embraces essentially all of the population and an increase in the price (roughly equivalent to the effect of a general sales tax) of all goods and services results, the lower income groups will ultimately contribute directly and indirectly, a percentage of income as great or greater than that shown in Column 6 of Table 17.

Other methods. Industrial and labor unions plans provide prepayment methods of paying for medical care which are similar to insurance plans. In certain industrial plans, the employer may provide at his own expense all medical care for his employees and their dependents. Other industrial plans vary according to services provided, proportion of cost paid by the employer, and the coverage of dependents. Some unions, such as the International Ladies Garment Workers Union, maintain their own system of medical service for members. Recently, a number of labor unions have negotiated contracts which bind the employer to pay to the union a certain percentage of his payroll, which the union uses for medical and other welfare purposes. All plans which depend upon contributions by employers are levies upon the incomes of those not covered by such plans, and may be expected to result ultimately, as they grow numerically great, in a system whereby the lower income groups of the general population pay disproportionately greater amounts of their income for medical care.

Medical care may also be paid for by persons or organizations legally responsible for certain persons or groups. The provision of medical care

^{38/} The figure of \$102 is, of course, less than these services would actually cost, being equal only to the cost of medical care exclusive of dental care.

for veterans is an example of public responsibility. Another example is found in Workmen's Compensation laws which require employers to pay for disease and disability acquired by workers in connection with their employment.

CHAPTER IV

THE PATTERN OF MEDICAL CARE IN NEW YORK STATE

Types of Service or Programs

The pattern of medical care in New York State is extremely complex with respect to type of service, eligibility, administration and responsibility for payment. Table 1 presents a descriptive compilation of the more important types of service. These have been divided into eight main groups:

1. Public medical care programs required of governmental agencies, financed by general taxes, and from which everyone may benefit according to need and without respect to economic status. This group includes the medical inspection of school children (adopted 1913), the care of tuberculosis patients in county tuberculosis hospitals (adopted 1943), and the diagnosis and treatment of venereal disease in the State outside of New York City (adopted 1945). The recent adoption of the programs for free care of venereal disease and institutionalized cases of tuberculosis may or may not be indicative of a trend toward the provision of medical care for everyone from general tax funds, it being probable that both the necessity of preventing the spread of chronic communicable diseases, and the desirability of preventing chronic invalidism, poverty and financial dependence by relieving individuals and families of the heavy expenditures for the treatment of these diseases, were taken into consideration in enacting the laws.
2. Public medical care programs required of governmental agencies, financed by general taxes, and from which only certain classes of persons may benefit. The services in this group are for the greater part available only to those who undergo an investigation of economic status and are judged to be unable to pay for needed service. In some programs, however, a means test has been dispensed with because an overwhelming majority would be found eligible if a means test were applied.^{1/} This is illustrated by the Emergency Maternity and Infant Care Program for wives and infants of servicemen in the lower four pay grades, studies having shown that 95 per cent would be unable to pay. Hospital care of veterans for non-service-connected disabilities would seem to fall in this group.^{1/}

^{1/} The care of service-connected disabilities of veterans is a matter of public liability. Hospital care is provided to veterans for non-service-connected disabilities on the basis of a means test which is little more than a formality.

Table 1. Compilation of Various Types of Medical Care Available to Residents of New York State, With Respect to Type of Service, Eligibility, Administration and Responsibility for Payment.

Type of service or program	Eligibility for care	Administration	Responsibility for payment
1. PUBLIC MEDICAL CARE REQUIRED BY LAW - FINANCED BY GENERAL TAXES - EVERYONE MAY BENEFIT			
Medical inspection of school children	Public and many other school children	Local board of education or health	Locality
Care in county tuberculosis hospitals, outside of New York City	All residents of such counties	County	County
Venereal disease diagnosis and treatment, outside of New York City	Residents of State outside of New York City	Local board of health	Locality
2. PUBLIC MEDICAL CARE REQUIRED BY LAW - FINANCED BY GENERAL TAXES - CERTAIN PERSONS MAY BENEFIT			
Hospital care of veterans for non-service connected disabilities	Veterans unable to pay	Federal Veterans' Administration	Federal
Maternity and infant care for dependents of low-paid servicemen	Wives and infants of servicemen in lower four pay grades	State Health Department	As above
Treatment of narcotic addiction	Federal prisoners and selected voluntary patients	U. S. Public Health Service	As above
Vocational rehabilitation (including medical care for rehabilitation)	Persons physically or mentally handicapped for employment and unable to pay	State Education Department	Federal and State
Medical and hospital care for Old Age Assistance, Aid to Blind and Aid to Dependent Children cases	Indigent as determined by local welfare department	Local welfare department	Federal, State and locality
Medical care for Home Relief, Veterans Assistance and other needy cases	As above	Local welfare department	State and locality
Hospital care for Home Relief, Veterans Assistance and other needy cases	As above, and departments of health or hospitals in certain cities	Welfare, health or hospital departments	Locality
Physically handicapped children's care	Unable to pay as judged by children's court judge	State Health Department	State and county
Adult poliomyelitis care	Unable to pay as judged by local health officer	State Health Department	State, and county or New York City
Mental hospital care	Indigent as determined by Department of Mental Hygiene	State Department Mental Hygiene	State
Tuberculosis clinic care	Anyone referred by physician or health officer	State, county or city	State or locality
Care in Raybrook State Tuberculosis hospital	Unable to pay, as determined by hospital superintendent	State Health Department	State
Care in State tuberculosis hospitals, outside of New York City	Indigent as determined by local welfare department	As above	County
3. PUBLIC LIABILITY MEDICAL CARE, REQUIRED BY LAW - FINANCED BY SPECIAL PAYMENTS - CERTAIN PERSONS MAY BENEFIT			
Workmen's Compensation care	Occupational disease of selected employees	State Department of Labor	Employer
Hospital and clinic care of veterans for service-connected disability	Veterans with service-connected disabilities	Federal Veterans' Administration	Federal
4. PUBLIC MEDICAL CARE PERMITTED BY LAW - FINANCED BY GENERAL TAXES - EVERYONE MAY BENEFIT			
School nursing service	Public, and many other school children	Local board of education or health	Locality
Dental care of school children	As above	As above	As above
Communicable disease immunization	Residents	Local health departments	As above
5. PUBLIC MEDICAL CARE PERMITTED BY LAW - FINANCED BY GENERAL TAXES - CERTAIN PERSONS MAY BENEFIT			
Public health nursing service	Residents referred by physicians	State and local health departments	State and/or locality
Diagnosis and treatment of cancer	Residents of State outside of New York City referred by physician	State Health Department	State
Drugs and biologicals for communicable disease	As above	As above	As above
State laboratory service	As above	As above	As above
Drugs and biologicals for communicable disease	Unable to pay, as determined by attending physician	Local health department	Locality
Laboratory service other than State	As above	Local	State and/or locality
Child health supervision	As above	Local health department	Federal and/or State and/or locality
Dental care for non-school (or school) children	Unable to pay, as determined by attending physician or dentist	As above	As above
General clinic care	Indigent as determined by clinic	Local	Locality
Child guidance service	Unable to pay, as determined by attending physician or social agency	State Department Mental Hygiene	State
Communicable, venereal disease, orthopedic and other consultations	Unable to pay, as determined by attending physician	State or local health department	State and/or locality
General hospital care	Indigent as determined by hospital	Local	Locality
6. PRIVATE MEDICAL CARE FINANCED THROUGH PRIVATE PHILANTHROPY			
General and special hospital, clinic and dispensary care	Unable to pay, as determined by private agency	Private agency	Private agency
Visiting nurse service	As above	As above	As above
Industrial medical programs	Employees, and sometimes dependents	Employer	Employer
7. PRIVATE MEDICAL CARE FINANCED THROUGH MUTUAL BENEFIT ASSOCIATIONS			
All types of care	Members	Cooperative	Members
8. PRIVATE MEDICAL CARE FINANCED INDIVIDUALLY			
All types of care, direct service and insurance	Anyone	Individual or pre-payment agency	Individual

Note: Certain minor exceptions and qualifications have been deliberately omitted from this table in the interest of simplicity and, it is believed, without detracting from the main purpose of the table, which is to present a general descriptive picture. All programs are described in detail elsewhere in this report.

In other categories, a means test is applied by different agencies and according to differing standards. In general, the public welfare departments, which are responsible for providing the more ordinary types of service, employ standards which are relatively less generous than those employed by health, hospital and education departments and judges, who are responsible for determining eligibility under programs having a broader scope, e.g., the amelioration of conditions which handicap the individual for education or work.

3. Public liability medical care programs required by law, financed by special payments, and from which only certain persons may benefit. . Workmen's Compensation is a specialized type of liability program which by special law fixes upon the employer the responsibility for providing medical care to employees for accidents and illnesses attributable to the work performed for that employer. The care of veterans for service-connected disabilities is another example of a public liability medical care program.
4. Public medical care programs permissive for governmental agencies, financed from general tax funds, and from which everyone may benefit according to need and without respect to economic status. There are relatively few programs in this group. They include nursing care and dental service for school children, and immunization of all persons against communicable diseases. Although permission to operate such programs is of long standing, they have exhibited but a slowly increasing acceptance by localities.
5. Public medical care programs permissive for governmental agencies, financed from general tax funds, and from which only certain classes of persons may benefit. The services in this group are for the greater part available only to those persons who meet a sort of means test, i.e., whose financial need is determined by the attending physician. From all indications, a physician is likely to be much more liberal in his determination of eligibility for the types of free care covered in this group than is a governmental agency in respect to eligibility for hospital and general medical care. This liberality is perhaps influenced by the fact that most of the services are in the form of nursing and diagnostic services, and the provision of biological

cal preparations and certain drugs, which enable the physician to render better care to the patient. They not only do not deprive the physician of his patient but they render the patient better able to pay the physician. Also, this type of care is more readily sought by patients than hospital and medical care provided by official agencies, since the application of the so-called means test by the physician is so informal that often the patient is not even aware of it. The services rendered thus tend to escape the stigma of charity by being viewed as aids to the physician as much as aids to the patient.

6. Private medical care financed through private philanthropy. The programs in this group benefit persons who are rather carefully investigated and found unable to pay the full cost of service; in fact, eligibility for free or part-pay clinic care is restricted by law. The types of care provided are usually limited to hospital, clinic and visiting nursing care; home care by a physician is rarely included.

A considerable amount of free care, chiefly of the clinic variety, is provided to employees by employers to improve industrial efficiency, to reduce time absent from work, and to meet in part their obligations under the Workmen's Compensation Law. This type of care perhaps should be characterized as a condition of employment rather than philanthropy.

7. Private medical care financed through unions, associations of employees and other mutual benefit associations.^{2/} This type of program seems to be on the increase, especially in employee groups, because there is an increasing tendency on the part of employers to contribute a substantial part of the cost, either independently or pursuant to a contract with a labor union.
8. Private medical care financed individually. This group, which includes care paid for either directly or by insurance methods, and on personal initiative or legal responsibility, is the traditional form of service and the one most important quantitatively.

^{2/} It appears that the provision of medical care must be an incidental purpose of the association since, with reference to Section 10 of the Membership Corporations Law, it was stated that "An association cannot be incorporated under this section for the purpose of furnishing free medical services to its sick and needy members." Op. Atty. Gen., 1925, 35 St. Dept. 285.

Cost of Services or Programs

Detailed estimates of expenditures for physicians', dental, nursing, laboratory and hospital services, in total and under public medical care programs and through insurance organizations are presented in the following chapters. In this section, they are brought together to present a composite picture. Because information was obtained from the recipients of payment for service rather than those paying for services, it was not possible to obtain figures for certain items - drugs and appliances, optometrists' services, etc. The individual data are as exact as it has been possible to make them. Because the figures for public expenditures and for payments through insurance related to the years 1944 or 1945, and because the figures for total payments were available only for 1941 or 1942, it has been necessary, as described in Chapter IX, to adjust the figures for total payments upward by about 15 per cent to 30 per cent in order that all figures might correspond to the period 1944-45.

Tables 2 and 3 summarize the data in respect to type of service, source of funds and methods of payment. Approximately \$525 million is spent annually for physicians', dental, nursing, laboratory and hospital services, of which 75 per cent is from private funds, 20 per cent from public funds and 5 per cent under Workmen's Compensation. The source of funds varies markedly with type of service, ranging from 92 per cent public funds for mental hospital care to less than 1 per cent public funds for private-duty and practical nursing care.

Of public funds, 88 per cent is spent for hospital care, and less than 5 per cent for physicians' and dental services. Of private funds, only 24 per cent is spent for hospital care, and 70 per cent is spent for physicians' and dental services.

Table 4 shows the percentage of private expenditures made through insurance or prepayment methods. 2 per cent of payments for physicians' services, 24 per cent of payments for general hospital services, and 23 per cent of payments for visiting nurse services are made through insurance, prepayment or related methods. Tables 5, 6, 7, 8, and 9 present more detailed analyses of expenditures of the various types.

Table 2. Estimated Annual Expenditures for Physicians', Dental, Nursing, Laboratory and Hospital Services, by Type of Service and Source of Funds, New York State, 1944-45 a/

Type of service	Public	Workmen's Compensation	Private b/	Total
Total amounts (millions)				
Physicians' <u>c/</u>	\$ 3.927	\$ 18.320	\$187.753	\$210.000
Dental	.964	-	88.036	89.000
Nursing <u>d/</u>				
Visiting <u>e/</u>	5.727	-	1.798	7.525
Other	.213	-	23.000	23.213
Hospital				
General <u>f/</u>	43.904	7.855	88.241	140.000
Mental	35.850	-	3.000	38.850
Tuberculosis	12.000	-	2.500	14.500
Laboratory <u>d/</u>	1.967	-	.800	2.767
Total	104.552	26.175	395.128	525.855
Percentage distribution by source of funds				
Physicians' <u>c/</u>	1.9	8.7	89.4	100.0
Dental	1.1	-	98.9	100.0
Nursing <u>d/</u>				
Visiting <u>e/</u>	76.1	-	23.9	100.0
Other	0.9	-	99.1	100.0
Hospital				
General <u>f/</u>	31.4	5.6	63.0	100.0
Mental	92.3	-	7.7	100.0
Tuberculosis	82.8	-	17.2	100.0
Laboratory <u>d/</u>	71.1	-	28.9	100.0
Total	20.0	5.0	75.0	100.0

a/ Figures are mutually exclusive.

b/ Includes expenditures by organized philanthropies.

c/ Exclusive of payments made as a part of hospital or laboratory service, which are included in figures for such services; also exclusive of payments for services as health officers, teachers, etc.

d/ Exclusive of nursing provided as a part of hospital service.

e/ Combines bedside care and health instruction.

f/ Includes nursing home care paid for from public funds, in the amount of \$0.839 million.

Table 3. Distribution of Estimated Annual Per Capita Expenditures for Physicians', Dental, Nursing and Hospital Services, by Type of Service and Source of Funds, New York State, 1944-45^a

Type of service	Per capita expenditures			
	Public	Workmen's Compensation	Private ^{b/}	Total
Physicians' ^{c/}	\$.29	\$ 1.33	\$ 13.65	\$ 15.27
Dental	.07	-	6.40	6.47
Nursing ^{d/}				
Visiting				
Bedside care	.03	-	.11	.14
Health instruction	.39	-	.02	.41
Other	.02	-	1.67	1.69
Hospital ^{e/}				
General	3.19	.57	6.42	10.18
Mental	2.61	-	.22	2.83
Tuberculosis	.87	-	.18	1.05
Laboratory ^{d/}	.14	-	.06	.20
Total	7.60	1.90	28.74	36.24
Percentage distribution by type of service				
Physicians' ^{c/}	3.81	70.00	47.50	39.93
Dental	.92	-	22.27	16.92
Nursing ^{d/}				
Visiting				
Bedside care	.39	-	.38	.37
Health instruction	5.13	-	.07	1.07
Other	.26	-	5.81	4.42
Hospital ^{e/}				
General	41.95	30.00	22.34	26.62
Mental	34.32	-	.77	7.40
Tuberculosis	11.44	-	.63	2.75
Laboratory ^{d/}	1.84	-	.21	.52
Total	100.0	100.0	100.0	100.0

^{a/} Figures are mutually exclusive.

^{b/} Includes expenditures by organized philanthropies.

^{c/} Exclusive of payments made as a part of hospital or laboratory service, which are included in figures for such services; also exclusive of payments for services as health officers, teachers, etc.

^{d/} Exclusive of service provided as a part of hospital service.

^{e/} Includes nursing home care paid for from public funds in the amount of \$0.839 million.

Table 4. Estimated Percentage of Private Medical Expenditures Through Prepayment and Other Insurance Methods, New York State, 1944-45

Type of service	Total <u>a/</u> (millions)	Prepayment <u>b/</u>	
		Amount (millions)	Per cent
Physicians <u>c/</u>	\$187.753	\$ 3.750	2.0
Dental	88.036	-	-
Nursing <u>d/</u>			
Visiting	1.798	.415 <u>e/</u>	23.1
Other	23.000	-	-
Hospital			
General	88.241	20.858	23.6
Mental	3.000	-	-
Tuberculosis	2.500	-	-
Laboratory <u>d/</u>	.800	-	-
Total	395.128	25.023	6.3

a/ Includes payments by philanthropic agencies.

b/ Includes all private (commercial) and other voluntary - industrial and union, medical and hospitalization insurance plans. Does not include dental benefits of such plans (which are very few), or hospitalization for tuberculosis or mental disease (which is negligible in amount).

c/ Exclusive of payments made as a part of hospital or laboratory service, which are included in figures for such service.

d/ Exclusive of service provided as a part of hospital service.

e/ Paid by life insurance companies on behalf of holders of life insurance policies.

Table 5. Estimated Annual Expenditures for Physicians' Services, New York State, 1944-45 (In Millions)

Program and source of funds	Amount	Per cent of total
1. PUBLIC FUNDS <u>a/</u>	\$ 3.927	1.79
a. Public welfare medical programs	1.453	
b. Emergency Maternity & Infant Care Program	1.319	
c. School medical inspections	.890	
d. Venereal disease treatment	.231	
e. Crippled children's program	.032	
f. Cancer clinic service	.002	
2. WORKMEN'S COMPENSATION	18.320	8.33
3. PRIVATE FUNDS	187.753	85.34
a. Insurance, private (commercial) plans	1.250	
b. Insurance, non-profit plans	2.500	
c. Individual arrangement	184.003	
4. UNCLASSIFIED <u>b/</u>	10.000	4.54
TOTAL	220.000	100.00

a/ Exclusive of health officers' salaries and fees, physicians in public tuberculosis, mental and veterans hospitals.

b/ Estimated. Includes health officers' salaries (\$1,375,000), and payments to teachers, administrators, coroners, hospital radiologists, anesthesiologists, etc. Perhaps 50 per cent or more of this amount is included in hospital figures.

Table 6. Estimated Annual Expenditures for Hospital Services,^{a/} New York State, 1944-45 (In Millions)

Type of program & source of funds	General ^{b/}	Tuber- culosis	Mental ^{c/}	Total	Per cent of total
1. PUBLIC	\$ 43.904	\$12.000	\$35.850	\$91.754	47.45
a. General public funds ^{d/}	29.630	9.923	32.588	72.141	
b. Public welfare	5.700	.500	-	7,200	
c. Veterans Administration	3,461	1.577	3.262	8,300	
d. EMIC	1.694	-	-	1.694	
e. Crippled children	1.637	-	-	1.637	
f. Cancer hospitals	.782	-	-	.782	
2. WORKMEN'S COMPENSATION	7.855	-	-	7,855	4.06
3. PRIVATE	38.241	2.500	3.000	93.741	48.48
a. Insurance, private (commercial) plans ^{e/}	2.322	-	-	-	
b. Insurance, consumer and industrial plans ^{e/}	.678	-	-	-	
c. Insurance, Blue Cross ^{e/}	17.853	-	-	-	
d. Individual arrangement	67.333	-	-	-	
TOTAL ^{d/}	140.000	14.500	38.850	193.350	100.0

^{a/} Includes all hospitals, generally, and \$0.839 million for nursing home care paid for from public funds. Also includes payments to salaried physicians in hospitals.

^{b/} Excludes departments of institutions.

^{c/} Excludes schools for the mentally deficient.

^{d/} Excludes \$2.5 million estimated to have been received from public welfare departments.

^{e/} Includes only sums paid out to hospitals.

Table 7. Estimated Annual Expenditures for Dental Services,^{a/} New York State, 1944-45. (In Millions)

Type of program and source of funds	Amount	Per cent of total
1. PUBLIC FUNDS	\$.964	1.07
a. Preschool children	.024	.03
b. School children	.711	.79
c. Public welfare	.229	.25
2. PRIVATE	88.036	97.52
3. UNCLASSIFIED	1.000	1.11
TOTAL	90.000	100.00

^{a/} Includes services of dental hygienists, and costs of dentures.

^{b/} Includes payments to teachers, dentists in employ of clinics, hospitals, etc.

Table 8. Estimated Annual Expenditures for Nursing Services,^{a/}
New York State, 1944-45.

Type of program and source of funds	Amount (millions)	Per cent of total
1. PUBLIC FUNDS	\$ 5.935	19.31
a. Health department nurses		
Bedside care	.145	
Health instruction, etc.	3.492	
b. School nurses		
Bedside care	-	
Health instruction, etc.	1.887	
c. Public welfare ^{c/}	.213	
d. Visiting nurse agencies (private)		
Bedside care	.103	
Health instruction, etc.	.018	
e. Orthopedic nurses	.047	
f. EMIC nursing	.030	
2. PRIVATE FUNDS	24.803	80.69
a. Visiting nurse agencies (private)		
Bedside care	1.528	
Health instruction, etc.	.270	
b. Health department nurses		
Bedside care	.005	
Health instruction, etc.	-	
c. Registered nurses, private duty ^{a/b/}	12.000	
d. Practical nurses ^{b/}	11.000	
TOTAL	30.738	100.0

^{a/} Does not include expenditures for nursing as a part of hospital service, but does include private-duty nursing in hospital.

^{b/} Estimated; 15 per cent of national total.

^{c/} There may be some duplication of amounts received by visiting nurse agencies for care from public funds.

Table 9. Estimated Annual Expenditures for Laboratory Services,^{a/} New York State, 1944-45.

Source of funds	Amount (millions)	Per cent of total
Public	1.967	71.1
Private ^{b/}	.800	28.9
Total	2.767	100.0

^{a/} Includes only examinations on behalf of individuals, and excludes examinations of milk, water, etc. Does not include services provided as a part of hospital services, etc.

^{b/} Includes estimate for New York City based on data for rest of State.

CHAPTER V

PUBLIC MEDICAL CARE

(MATERNAL AND CHILD HEALTH SUPERVISION, EMERGENCY MATERNITY AND INFANT CARE PROGRAM, DENTAL SERVICE FOR PRESCHOOL CHILDREN, SCHOOL HEALTH SERVICE, PHYSICALLY HANDICAPPED CHILDREN, PUBLIC HEALTH NURSING AND LABORATORIES)

Definition and Scope

The purpose of the chapters on public medical care is to describe the medical programs and facilities which are financed by public moneys which provide medical services directly to the individual. Services supplied chiefly as community protective measures, e.g., sanitation, immunization against communicable diseases, health education, etc., have been largely excluded. As indicated in the chapters on the pattern of medical care in New York State, the number of programs and agencies involved is great and their functions are interlocking and sometimes overlapping, which prevents rigid grouping by type of program or administrative agency. In the sections that follow, some continuity is provided by juxtaposition of programs related in type of service.

In the study of public medical care programs an effort was made in each instance to obtain a brief description of the objectives of the program, the legal basis for it, the regulations governing eligibility of persons for the services provided, the volume of service rendered, the amounts and methods of payment, and the source of funds. Each agency supplying data was asked also to comment on the adequacy of the service and of its financial support, and to suggest legislative action that might help to make the program more effective.

Maternal and Child Health Supervision

In the field of maternal and child health a distinction is ordinarily made between supervisory services provided to apparently well persons, such as instruction of the individual in diet and hygiene, examination for detection of abnormalities, etc., and the treatment of disease, correction of defects and the delivery of infants. This section is largely confined to the health supervisory services, which are administered chiefly by departments of public health and education.

Recognition of the interest and responsibility of the State in maternity and child health led to the creation in New York State in 1913 of the first State division of child hygiene. The function of New York State in this field has been one of supervision, consultation, guidance and en-

couragement to the localities to handle this problem themselves. As acceptance of the importance of this program developed, Federal funds were made available in 1923 to assist the State in this work.^{1/}

Authority for State activity in child welfare for the State is affirmed in the State Constitution,^{2/} which assures the right of the Legislature to provide for health and welfare services for all children, either directly or through subdivisions of the State. The Legislature has used this power in the Public Health Law, Sections 18-b, 18-c, 19 and 19-d, which delegate to the State Commissioner of Health the function of cooperating with and stimulating local agencies, public and private, to adopt measures to safeguard motherhood, save infant life and prevent diseases and defects of childhood. The Commissioner is responsible for the supervision of any local programs which receive State aid granted under Section 19-f for establishing and maintaining clinics for these purposes. The New York City Charter likewise recognizes the responsibility of the City for providing for maternal and child health.^{3/}

Prenatal health supervision. Today, almost all prenatal health supervision is rendered in hospital out-patient departments, or by private physicians, in accordance with the belief of public health officials that "prenatal care should be rendered by the medical service which is responsible for delivery and post partum care, and that a necessary part of such care is the provision of hospital beds as needed in any phase of the maternity cycle."^{4/} Such service as is provided from public funds is given through clinics manned by physicians paid on a salary or per-session basis.

Outside of New York City, 17 prenatal clinics were operated by health

Table 1. Cost of Operation and Source of Funds of Publicly Financed Prenatal Clinics, New York State, 1944

Area	Cost of operation	Source of funds	
		State	Local
New York City	\$2,178	\$ 0	\$2,178
Rest of State	6,681 ^{a/}	1,458	5,223
Entire State	8,859	1,458	7,401

^{a/} Data incomplete

departments in 1944, of which 13 were in cities and 4 in counties, the latter being financed jointly by State and county. Exact figures are not available as to

^{1/} At present, Federal funds are available under the Social Security Act, Title V, Part 3, through grants-in-aid administered by the U.S. Children's Bureau. The State Public Health Law, Section 19-c, empowers the State Health Department to administer such funds.

^{2/} Article VII, Section 9.

^{3/} Section 556.

^{4/} Report to Commission by State Health Department. A similar view is expressed in the New York City Health Department 1938 Annual Report, Health for New York City's Millions.

service rendered, since in the records of the State Health Department there are included the activities of 4 clinics operated by visiting nurse associations and 2 by industries. Including these non-official clinics, 1515 persons made an average of 3.7 visits each. The cost data shown in Table 1 for the State outside of New York City apply only to 9 of the 17 health department clinics.^{5/} It is probable that the cost per visit averaged between \$1.50 and \$2.00.

In New York City, the system of prenatal clinics maintained by the City Health Department has been almost entirely discontinued, only 5 clinics being operated in 1944. 832 patients averaged 4 visits each, at a total cost of \$2,178 (see Table 1) and an average cost of \$0.66 per visit. The great bulk of publicly financed prenatal health service is furnished by the out-patient departments of the public hospitals.^{6/}

Child health supervision. This program centers around the operation of clinics manned by physicians paid on a salary or, more frequently, a per-session basis. Aside from immunization against communicable diseases, little medical treatment is given to the child. As a rule, the visit consists of examination of the child by a physician in the presence of the parent and a public health nurse, at which time general health instruction is given and the parent's attention is called to defects to be corrected through the parent's own resources, or through public or private charitable agencies if the parent is unable to pay. The public health nurse maintains a record of the defects found and endeavors through periodic visits to the child's home, and in the case of a needy family through her contacts with various resources of free or low-cost medical care, to persuade and assist the parent to have the child's defects remedied. At the child health clinics (or child health conferences, as they are usually called to indicate the large proportion of health teaching to medical treatment) which receive State funds, a dental hygienist is usually present to clean and examine the child's teeth and give instruction in dental health. In addition, individual or group demonstrations of some of the more homely aspects of child care, and talks on nutrition, etc. may be given to the parents by the public health nurse in attendance.

The data furnished by the State Health Department for the State outside of New York City include some clinics financed by non-official agen-

^{5/} These agencies held 644 clinic sessions at 15 clinics in cities. Data on the number of visits made to these clinics are not available.

^{6/} 108,018 visits were made to the obstetrical and gynecological clinics of New York City public hospitals in 1944.

cies such as local public health committees, visiting nurse associations, industries and other groups. However, a majority of the clinics outside of hospitals are conducted by health departments. In 1944 there were 315 child health clinics operated in 248 communities in 37 counties of the State excluding New York City (see Figure 1). These clinics usually admit only children who have been referred by, or whose attendance has been approved by, the private family physician. Such referral or approval implies that the private physician considers the child or family financially eligible for free care of this type. Clinics receiving State funds are supposed to be open to all children from birth to 6 years of age regardless of financial status, but the usual (although not uniform) practice of requiring referral by a physician serves as a sort of means test, although it may not be required for this purpose. Referral by a physician is considered desirable in order that recommendations for correction of defects, etc., may be transmitted to a designated physician, and in order to lessen the possibility of having a child under the observation of two different physicians at the same time, without either being aware of what the other is doing.

Table 2. Child Health Clinics. Number of Clinics, Visits, and Individuals Seen, New York State, 1944.

Area	Clinics	Visits	Individuals
New York City	62	315,100 ^{a/b/}	89,147 ^{a/c/}
Rest of State	315	99,216 ^{d/}	21,612 ^{d/}
Entire State	377	414,316	110,759

^{a/} In addition, 24,348 children were immunized against smallpox and 26,605 against diphtheria.

^{b/} Exclusive of 107,698 visits where only a nurse was seen.

^{c/} 38,243 visits by infants and 50,904 by pre-school children.

^{d/} Data incomplete.

Note: The average number of visits per individual varies greatly throughout the State, depending on the frequency of the clinics. Several clinics hold less than one session a month, while others hold sessions one or more times a week.

The number of individuals seen in child health conferences and the number of visits made are shown in Table 2.^{7/} Data on cost of service are available only for 253 clinics conducted by official health agencies in 191 communities as indicated in Table 3.^{8/}

^{7/} Data on number of clinics, number of visits and number of individuals is understated, as returns for several communities are incomplete.

^{8/} Service data for the corresponding clinics were not available separately.

Encircled figures indicate number of clinics.
Figures that are not encircled indicate number
of clinic sessions.

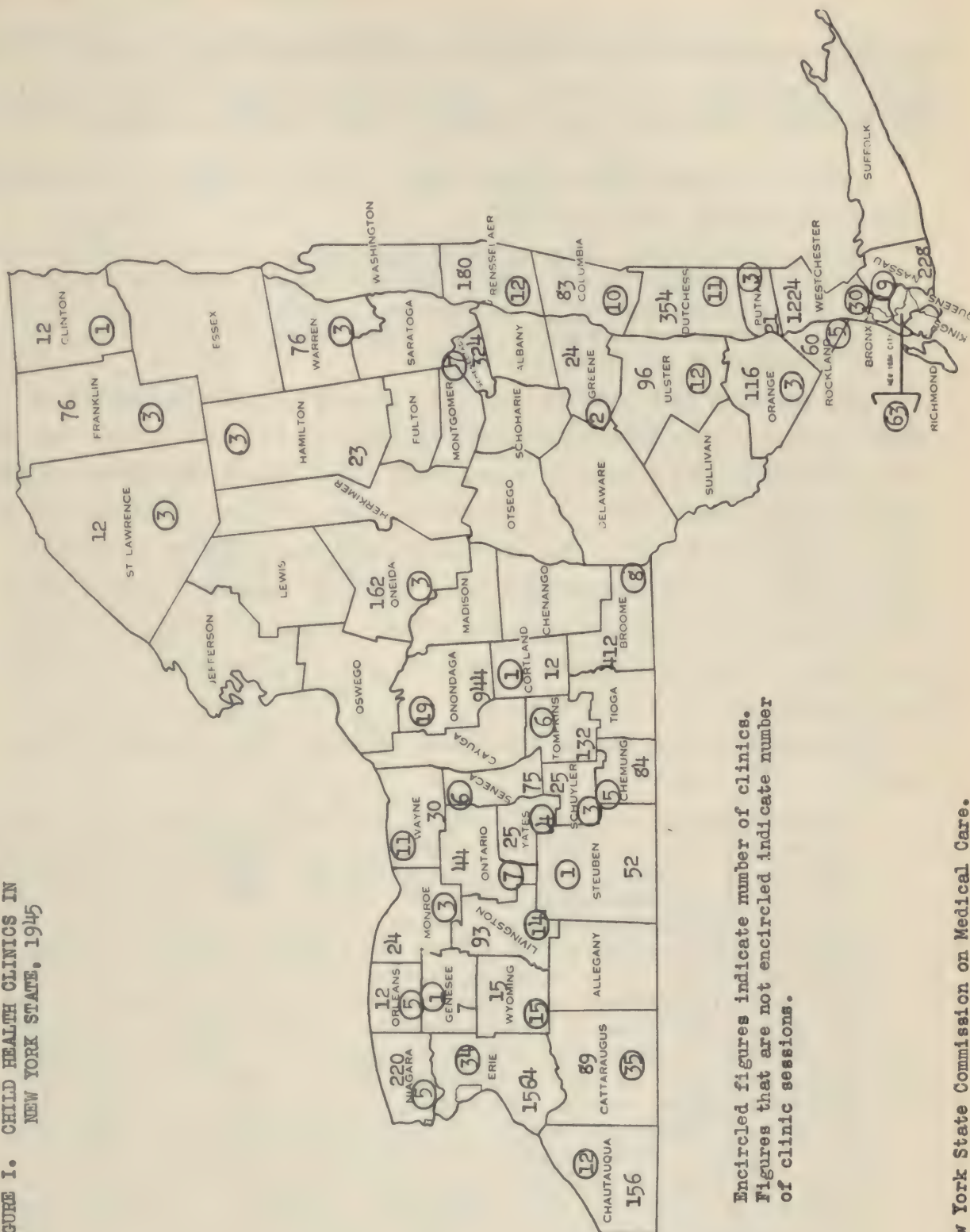


Table 3. Cost of Operation and Source of Funds of Selected Child Welfare Clinics in New York State, 1944

Area	No. of clinics	No. of sessions	Cost of operation	Source of funds			
				Federal	State	Local	
						Public	Private
New York City	62	-	\$421,314	\$4,390	\$ 0	\$416,924	\$ 0
Rest of State	253	5,728	78,161	1,133	11,284	64,743	1,001
Entire State	315	-	499,475	5,523	11,284	481,667	1,001

The New York State Health Department evaluates services in the State, outside of New York City, as follows:

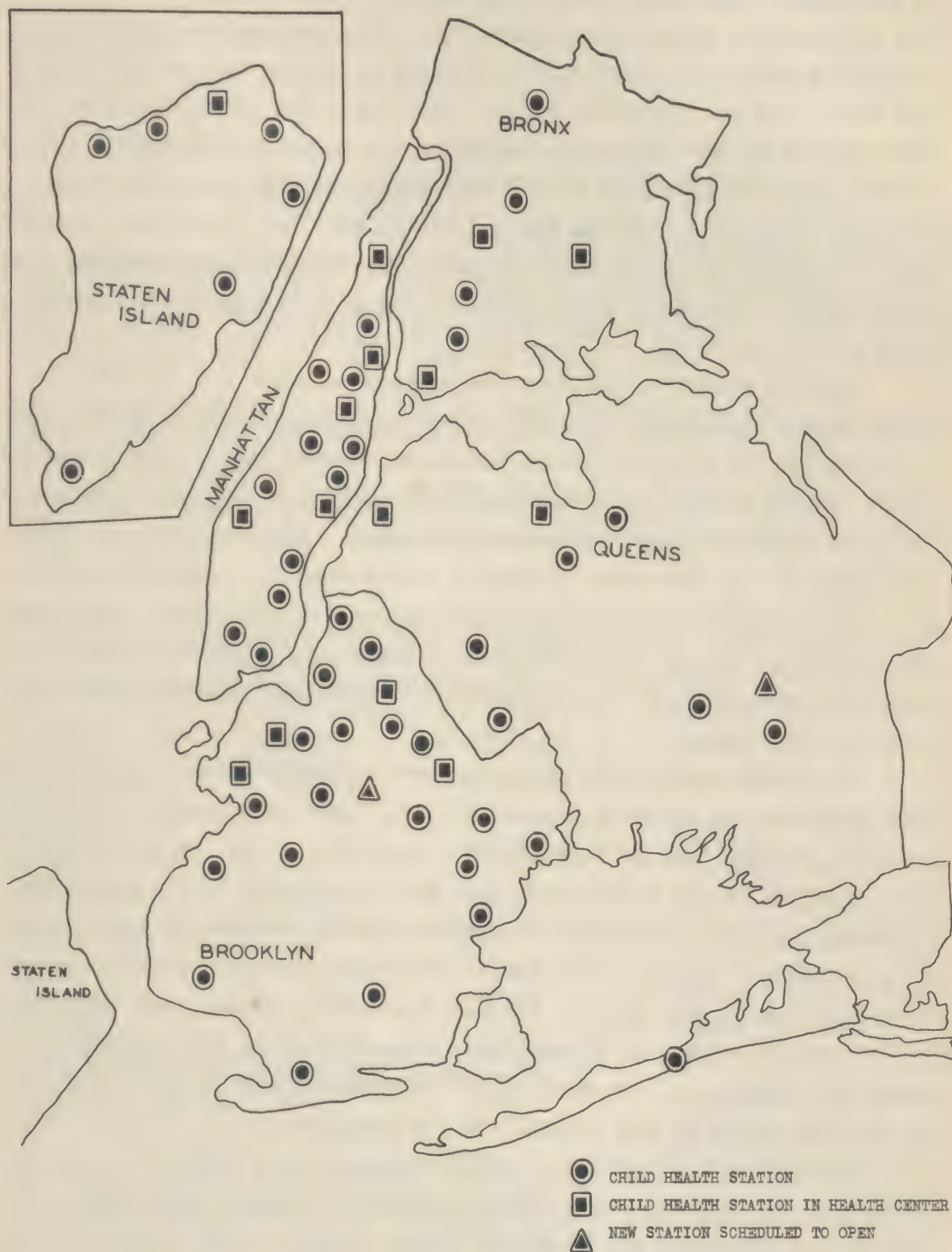
Twenty of the fifty-seven upstate counties have no child health clinic service. The service that is provided in the other thirty-seven counties is believed to be inadequate in amount and distribution to meet the need for continuous medical health supervision of all children unable to purchase this service.

The New York City program provides, through 62 clinics located as shown in Figure 2, complete pediatric supervision for well infants and pre-school children with a view to maintaining their health and educating their parents as to proper care. The volume and cost of clinic services are indicated in Tables 2 and 3. In addition to the usual content of a child health conference, 24,348 children were immunized against smallpox and 26,605 against diphtheria. During the year, immunization against whooping cough as early as 6 months of age, if possible, was adopted as a routine procedure for all City clinics.

The New York City Health Department comments on its service as follows:

The child health service is doing an adequate job within the present limitations of its budget. It is urgently necessary that physicians' salaries be raised to a level high enough to require that physicians have excellent training in pediatrics and to assure attracting the interest of physicians who are either eligible for licensure by the American Board of Pediatrics or who are already diplomates of the American Board. It is essential that this division have ready access to a qualified medical social worker who can act as liaison between our child health stations and community social agencies. As regards eligibility, it should be made clear that well child supervision is freely available to all the taxpayers of the community without regard to financial status. In such a case it will be necessary to broaden and expand the amount of service now rendered to take care of large segments of the middle income group who would be interested in using child health stations. Eventually, it will be necessary to inaugurate at least as a pilot experiment, diagnostic and therapeutic services for children as part of our present well child supervision, to ensure continuity of medical care. At no time should any payment be required for any of the services rendered under the present program.

FIGURE 2. LOCATION OF CHILD HEALTH STATIONS OF THE NEW YORK CITY DEPARTMENT OF HEALTH, 1945



Emergency Maternity and Infant Care Program.

The Emergency Maternity and Infant Care Program (EMIC) was set up by the Federal government in 1943 to provide, wholly at Federal expense, maternity and infant care to the wives and infants of persons on active duty in the lower four pay grades of the armed forces. The financial status of the patient does not affect eligibility. This program was adopted as a war-time measure, to cease within 6 months following the declaration of the end of the war emergency period. On a national basis, the plan is administered by the Children's Bureau of the Department of Labor, and on a State level by the State Health Department and, for the City of New York, by the Bureau of Child Hygiene of the New York City Health Department. The program is regulated by rules incorporated in a State plan prepared by the State Department of Health and approved by the Children's Bureau.

Complete prenatal, delivery and postpartum care, and the care of other medical conditions incident to and occurring during pregnancy are provided for the mother. During the first year of life, infants are eligible for all medical care required by illness, and for health supervision and communicable disease immunization as well. EMIC benefits are available only if the individual agrees to accept them for complete service: i.e., the individual may make no extra payment to physicians, hospitals, etc., nor in the case of hospitalized illness or confinement may she choose to have EMIC pay the hospital bill while she pays the physician's bill, or vice versa.

All needed medical and hospital services are provided, including general practitioner service, specialist care, hospital service, consultant service, special nursing, anesthesia, ambulance, x-ray, oxygen, visiting nurse service in the home, etc. Care may be provided by any physician licensed to practice medicine in New York State. A panel of specialists and consultants set up by the Health Department includes physicians certified by one of the American Medical Specialties Boards, and physicians not so certified who can present evidence of training and experience which are adequate in the opinion of the Commissioner of Health and/or an advisory board he may appoint for the purpose.

Hospitals are eligible to provide service after inspection and approval by the Commissioner of Health based on "Minimum Requirements for Approval of Hospitals and Maternity Homes" issued by the Children's Bureau, March 30, 1943.

Payment for service is made by the State Health Department or the

New York City Health Department from Federal grants. Physicians are paid on a fee-for-service basis, using a fee schedule established for this program. A differential in fees is allowed for work by specialists. Hospitals are paid on a cost basis providing the cost does not exceed certain limits. In general, the fees and costs paid under this program are higher, and more closely approximate the usual charges to self-supporting persons, than has been true of any public medical care program hitherto.

Table 4. Maternity and Infant Cases under the EMIC Program;
Number and Cost of Cases Closed in 1944^{a/}

Area	No. of cases		Cost of cases			
	Maternity	Infant	Total		Per case	
			Maternity	Infant	Maternity	Infant
New York City ^{a/}	15,480	1,904	\$1,690,070 ^{b/}	\$120,079 ^{c/}	\$109.18	\$63.07
Rest of State	11,431	1,581	1,188,364 ^{b/}	58,138 ^{c/}	104.01	36.77
Entire State	26,911	3,485	2,879,034	178,217	d/	d/

a/ Year ended June 30, 1945. Cases closed are those closed with some payment having been made.

b/ Cost divided as follows: 44 per cent physicians (2 per cent consultation), less than 1 per cent nurses, less than 1 per cent clinics, 55 per cent hospitals, all other less than 1 per cent.

c/ Cost divided as follows: 29 per cent physicians, 1 per cent nurses, less than 1 per cent clinics, 62 per cent hospitals, 7 per cent all other.

d/ Not computed because different periods employed for New York City and rest of State.

Table 5. Average Cost for Specified Types
of Service in EMIC Cases for New York State,
Exclusive of New York City, 1944^{a/}

Type of service	Cases where used	Av. cost of service
Maternity		
Physicians	10,561	\$47.74
Consultations	804	24.05
Nurses	112	24.88
Clinics	2	3.75
Hospitals	10,419	63.24
Infants		
Physicians	b/	\$ b/
Consultations	b/	b/
Nurses	26	29.46
Clinics	1	-
Hospitals	507	71.89

a/ Data include intercurrent diseases as well as maternity care.

b/ Information not available.

The number of maternity and infant cases in which service was completed, and the cost of these cases is shown in Table 4. The higher cost for infant cases in New York City is probably due to the fact that they were incurred in a later period than those in the rest of the State. Also, the program at first covered health supervision

of infants only if performed by a physician qualified as a pediatrician, and there are more qualified pediatricians in New York City than in the rest of the State. Later, all physicians were made eligible to provide this service, and the later period covered by the New York City figures would tend to further increase this item.

Table 5 shows, for the State outside of New York City, the average cost of specified services in cases where such services were used.

Dental Service for Pre-School Children

The accumulated dental neglect of the years is so vast that to attempt to deal with it at one stroke would require personnel and funds far beyond those available at this time. Most students of the problem of dental care agree that the logical method of approach is to begin with children before the ravages of dental decay have been great, and to carry these children along through the years in a dental program, adding each year the children who become two or three years old. Early training in oral hygiene and nutrition, and the overcoming of groundless fears of dental treatment will establish habits that will contribute to dental health in later years. Experiments of great potential value are being conducted by the State Health Department in adding fluorine to drinking water in an amount which will be harmless but which will be sufficient to prevent or retard dental decay in children. In the meantime, and probably for always, a program for the promotion of good dental habits and the early correction of decay and other dental faults is a most important health need.

In New York City, relatively little dental service is provided for pre-school children. In the rest of the State, dental service is an integral part of the child health program. Under this program, dental hygiene services are provided for children aged 2 to 6 years who attend the State-aided child health conferences previously described. Dental correc-

tive care is available without charge to such children in certain communities where the State Health Department is conducting demonstration programs or where a county participates in the cost under State-aid provisions.

Eligibility for care is

Table 6. Public Dental Hygiene and Correction Service for Pre-School Children, New York State Exclusive of New York City, 1944

Service data	Dental clinics	
	Hygiene	Correction
Communities	164	41
Clinic sessions	747	557
Children treated	4,640	943
Visits per child	1.03	3.38

based upon prior acceptance at a child health conference; thus the service is available only to those who have previously been judged unable to pay for child health service (except possibly a few isolated communities where there are no local dentists). In areas where local dentists are available and trained in childrens' dentistry, they are engaged on a per-session basis at a rate of \$12.50 for a 3-hour session, including dental supplies and

the use of the dentist's office. Elsewhere, a State Health Department trailer fitted out as a dental clinic and manned by State-employed dentists is utilized. Tables 6 and 7 and Figure 3 show the number and location of dental hygiene and correction clinics and the cost of service and

Table 7. Cost of Public Dental Hygiene and Correction Clinics, New York State
Exclusive of New York City, 1944.

Cost of service	
Dentists' salaries and fees	\$7,332
Dental hygienists' salaries and fees	5,768
Other personal service	11,404
Maintenance, etc.	a/
Total	24,504a/
Source of funds	
Federal	\$15,849
State	3,715
Local	558
Total	20,122b/

a/ Not available, and not included in total.

b/ Data on remainder of funds are not available.

source of funds. The program is at present very modest as regards volume of service and funds expended. A substantial part of the funds come from the Federal government under Title V, Part 1 of the Social Security Act.

The State Department of Health appraises this service as follows:

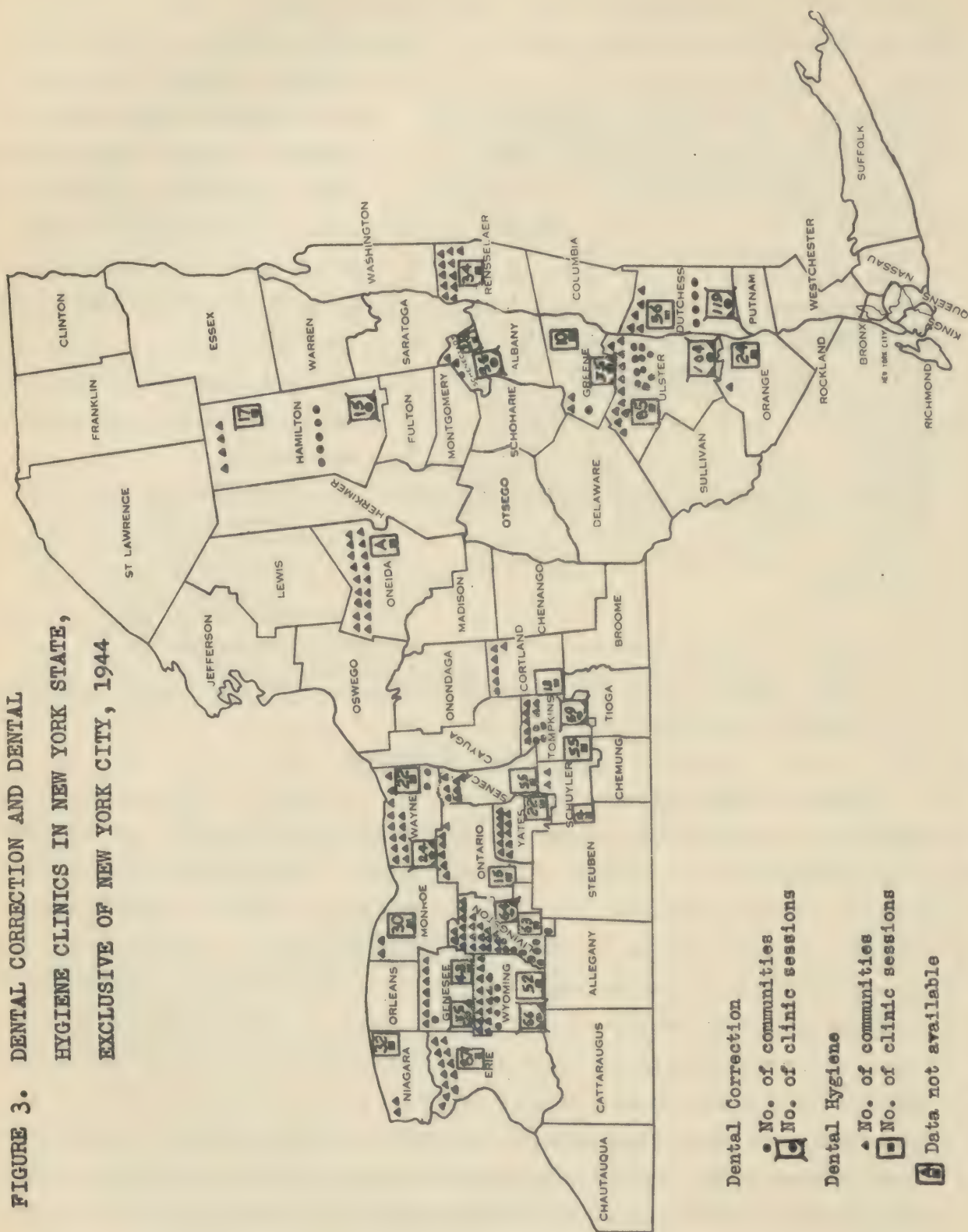
164 communities in 21 counties had the benefits of the dental hygienist's services. On the basis of need this service is wholly inadequate in amount and distribution.

It is the recommendation of the American Dental Association, Federal and State agencies, that dental care should be made more readily available to all children, especially through the primary grades.

School Health Service

School health services were originally developed to prevent the transmission of communicable diseases among school children, and it is probable that the compulsion to submit to school medical inspections, and the support of such service from public funds, are attributable to this origin. With the passage of time it has become apparent that if a child is to fully benefit from the educational opportunities offered to him he should not be needlessly handicapped by physical or mental ailments. In addition to its educational aspects, the objective of a school health program is to bring into relief the handicaps of body and mind which need correction, and to facilitate the correction of such conditions through private and public medical resources. School health services thus consist of medical inspection for all children, and corrective service for those unable to provide it from their own resources. The school health program closely resembles that of health supervision for children of pre-school age but, of course, reaches a much greater number of children.

FIGURE 3. DENTAL CORRECTION AND DENTAL HYGIENE CLINICS IN NEW YORK STATE, EXCLUSIVE OF NEW YORK CITY, 1944



Dental Correction


• No. of communities

[illegible]

Dental Hygiene

No. of communities

No. of clinic sessions

 Data not available

New York State Commission on Medical Care

Prior to 1913, medical inspection of some school children was conducted by local health officers and by the State Department of Health in cooperation with the State Department of Education. In that year, the State Education Law was changed to require medical inspection of all school children and its administration was lodged in the State Department of Education.

The State Education Law^{9/} requires local school boards, except in the cities of New York, Buffalo and Rochester, to provide an annual medical inspection of all public school children who do not present health certificates from their own physicians. An examination on returning to school after an illness is also required. In New York, Buffalo and Rochester, city charters and local ordinances require an equivalent service to be provided by the local health department. In the larger school districts the examinations are usually performed by salaried school physicians, but in the smaller districts the school physician is often paid on a per capita basis. In many instances the medical inspections are superficial affairs, and the recommendation has been made to "abandon the perfunctory but expensive annual 'physical examination' now required by law and have in its place one examination on school entrance, one on entering the seventh grade, one on entering the ninth grade, and one at the end of the twelfth grade."^{10/}

The law also authorizes the employment of school nurses, dentists, dental hygienists, nutritionists and optometrists or oculists to aid the medical inspector. The superintendent or other person in charge of the school is directed to notify parents of the existence of defects and physical disabilities in their children and to provide necessary care and treatment if the parents are unable or unwilling to do so.

School districts are required to provide the same health services to children attending other than public schools, if requested to do so by the authorities of such schools.

The cost of school health service is shown in Table 8. The State contributes to the cost in the same proportion as for other school expenditures, except where a county may have formed a school hygiene district, in which event the State will contribute one-half of the cost.^{11/}

^{9/} Sections 570-577c.

^{10/} Education for American Life, Report of the Regents Inquiry, McGraw-Hill, New York, 1938.

^{11/} Section 577-b, State Education Law. The work is under a district director of school hygiene, who is a physician meeting qualifications established by the State Commissioner of Education.

Table 8. Cost of School Health Services in New York State

Area	Medical inspection	Nursing service	Dental service	Other service	All services
New York City ^{a/}					
Total	\$256,611	\$ 709,700	\$399,636	\$ 30,581	\$1,396,528
Rest of State ^{b/c/}					
Cities	214,683	432,072	133,207	65,483	845,445
Villages	121,749	262,222	73,988	32,300	490,259
Rural	296,694	482,702	104,086	56,994	940,476
Total	633,126	1,176,996	311,281	154,777	2,276,180
Entire State ^{c/}					
Total	889,737	1,886,696	710,917	185,358	3,672,708

a/ Data for school year 1943-44, furnished by New York City Health Department.

b/ Data for school year 1942-43, Annual Report of State Department of Education, 1944.

c/ Exclusive of Rochester and Buffalo, whose expenditures are included in the general health department expenditures for those cities.

Concerning the general school health program, the comments made by the New York City Health Department relative to its program are probably of general application and point up the need for more adequate training and compensation of school physicians if public medical services of good quality are to be provided:

Quantitatively, the basic medical service is adequate to meet the needs of the present program. The latter would benefit from additional routine examinations and more time for the physician for each examination. To obtain full benefit, however, increased nursing service is highly desirable and higher quality of medical service almost essential. Physicians should meet the minimum qualifications for school physicians as recommended by the Committee on Administrative Practice of the American Public Health Association. To attract such men, considerably higher salaries will have to be offered. There is need for expansion in the consultant services, particularly otology and ophthalmology. Again, to obtain the services of properly qualified physicians for these services, considerably higher salaries must be offered.

Dental service for school children. Because of the large number of school districts and various individual arrangements involved, studies of

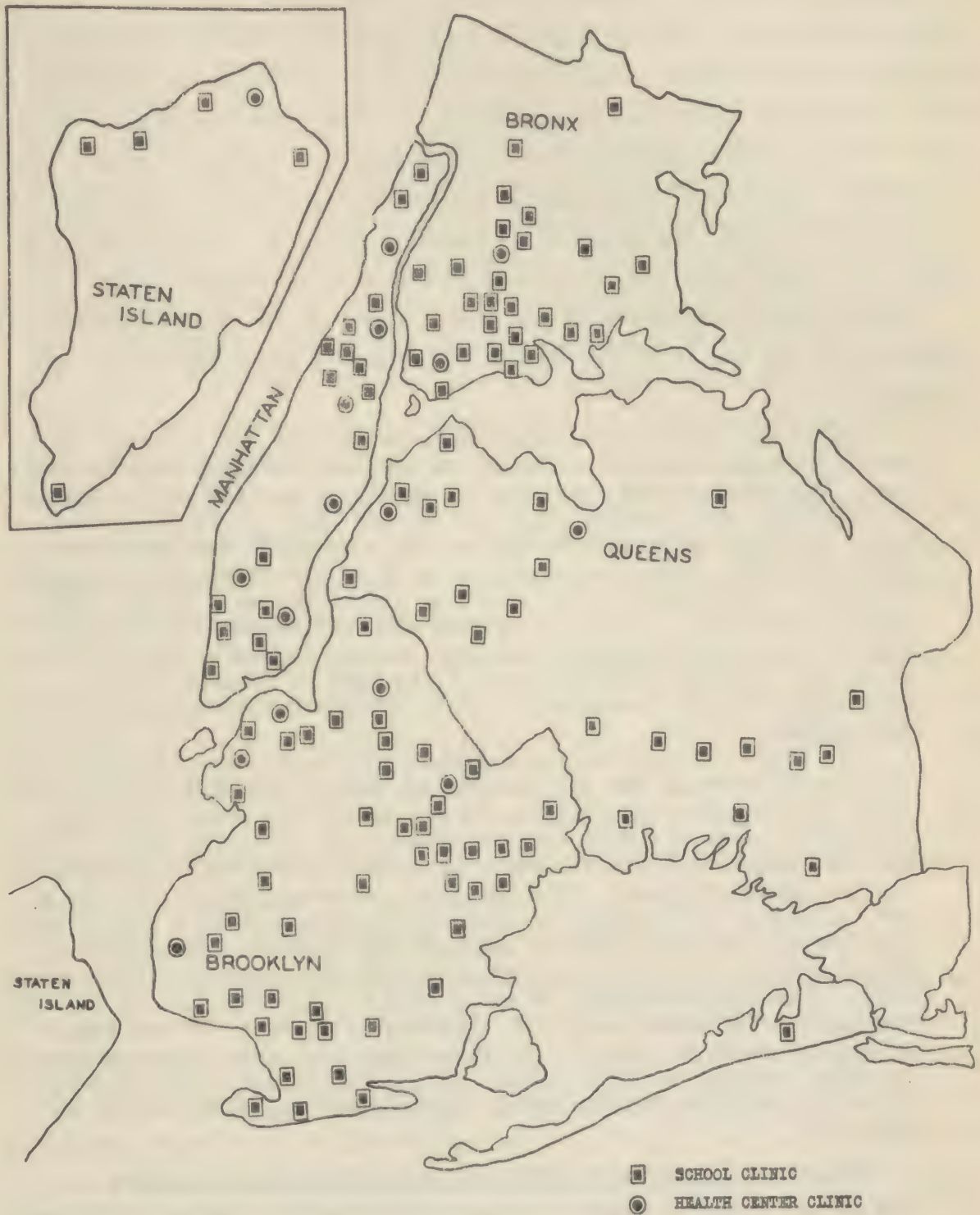
dental service for school children were limited to New York City. The Department of Health maintains 133 dental clinics in schools and health centers, as shown in

Table 9. Services Rendered by New York City Health Department Dental Clinics, 1943-44.

Type of service	No. of persons	No. of visits
Dental hygiene	32,431	32,766
Dental correction	20,253	148,754

Figure 4, employing 101 dental hygienists at a cost of about \$200,000, and 134 part-time dentists on a per-session basis at a cost of \$154,850. The volume of service provided in the year 1943-44, exclusive of classroom dental inspections, 179,000 cases referred to other agencies for den-

FIGURE 4. LOCATION OF DENTAL CLINICS OPERATED BY THE NEW YORK CITY DEPARTMENT OF HEALTH, 1945



tal hygiene, and 55,000 for correction services, is shown in Table 9. Although this volume of service may seem great in actual number, it appears small when compared with the number of school children.

The dental clinics located in schools offer dental service to children through the fourth grade, preference being given to those from kindergarten through the second year. The clinics located in health centers provide service to children beyond the fourth grade, to a very few pre-school children, and to older children applying for working papers. The services are limited to children whose parents are unable to pay for care from private dentists or part-pay clinics, the eligibility standard being an income of \$31 per week for a family with one child, and \$5 for each additional child.

An excellent commentary on the dental needs of children in general is furnished by the New York City Health Department's appraisal of its own program:

This service is considered adequate for the job on hand. The need for dental care is universal as has been shown by various studies. The reports made available by Selective Service on the health of selectees show conclusively that 21 per cent of our population could not meet the standards set by the Army which were very low; 6 anterior teeth, 3 in the upper jaw and 3 in the lower jaw in opposition; and 6 posterior teeth, 3 in the upper jaw and 3 in the lower jaw in opposition. In order to maintain the manpower needed for military purposes these minimum requirements had to be further lowered, and the Army took upon itself the task of rehabilitation. This necessitated a tremendous outlay for personnel, equipment and facilities.

In order to take care of a situation of this kind, we have to plan dental service for the younger age groups and continue the service. We consider the children of pre-school and school age to be the groups where the most lasting effects may be accomplished. The American Dental Association recently recommended a total children's program (3 to 18 years). The Institute of Dental Economics held at the University of Michigan in June of 1944 recommended a dental program for all children 3 to 18 years of age without a "means test." This Institute felt that service should be available to all children. Under these circumstances, we would have to plan for service to meet the needs of at least a million children in the City of New York. At present we have plans in the Department for increasing our service to serve 100,000 children without adding facilities. This figure of 100,000 children is for total completion - complete service to 100,000.

Physically Handicapped Children; Adult Poliomyelitis Cases

The sense of pity and desire to be of help which is evoked by a crippled child has led to a rather extensive public medical care program for physically handicapped children. The present State program originated in 1916 when the State Department of Health organized traveling orthopedic clinics to provide care for children who had been stricken by poliomyelitis

in the great epidemic of that year. The scope of service today is based in large part on 1926 legislation which outlined a definite program to provide rehabilitation services for crippled children.

A physically handicapped child is defined by law as "a person under 21 years of age who by reason of a physical defect or infirmity, whether congenital or acquired by accident, injury or disease is or may be expected to be totally or partially incapacitated for education or for remunerative occupation."^{12/} Such a child may be furnished surgical, medical or therapeutic treatment or hospital care and necessary appliances and devices either by the State Health Department,^{13/} or as the result of an order issued by a city or county Children's Court, of the New York City Commissioner of Health. In the latter cases, if the order is approved by the State Commissioner of Health, and the Children's Court decides that the parents cannot pay for the services ordered, one-half of the cost is paid by the State and the other half by the county or city in which the patient resides.^{14/} In 1942, an addition to the Public Health Law provided essentially the same service for persons over 21 years of age suffering from poliomyelitis, to be provided on authorization of the local health officer.^{15/} The cost of care of such persons is divided between State and county (or New York City).

The State Commissioner of Health has been authorized^{16/} to accept Federal funds available under Title V, Part 2 of the Social Security Act, for the purpose of finding and providing restorative services to children who are crippled or who are suffering from conditions which may lead to crippling. Although to date services have been furnished almost exclusively for orthopedic conditions, a program for non-orthopedic conditions such as heart disease and rheumatic fever, is being developed.

Clinic and consultation service. In New York City, nearly all of the public diagnostic or clinic services for physically handicapped children are provided through the public hospital out-patient departments, the City Health Department's limited clinic and consultation service reaching only 340 children in 1944 at a total cost of about \$3600. The most important activity of the Department lay in planning and coordinating services available through other agencies. The activities relating to ap-

^{12/} State Education Law, Section 1019.

^{13/} In practice, this procedure is not used.

^{14/} State Education Law, Section 1021-2.

^{15/} Public Health Law, Section 19¹/₂.

^{16/} Ibid., Sections 19c and 19d.

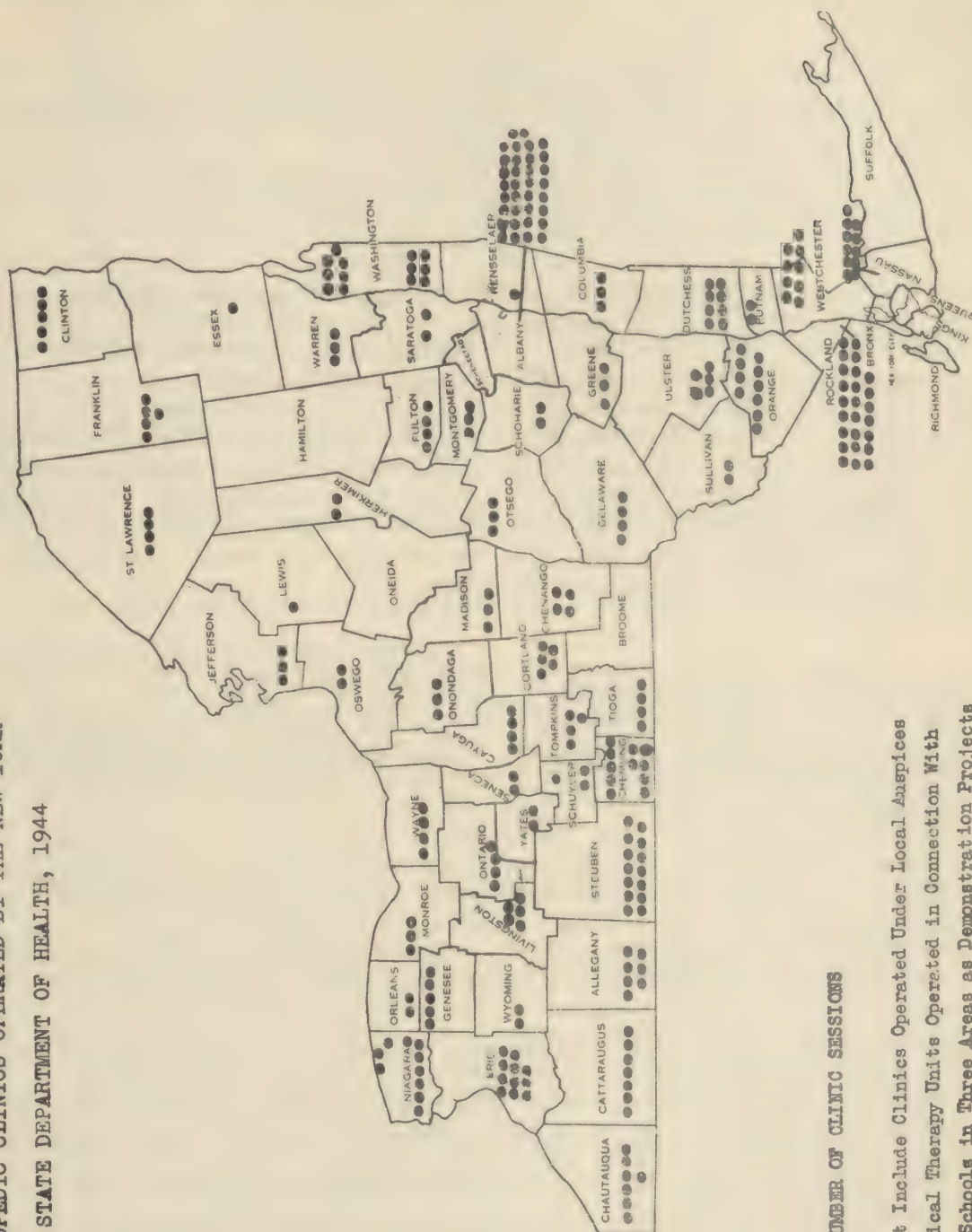
proval of orders for operative procedures, hospitalization, etc. are centered in the State Department of Health.

Outside of New York City, the State Department of Health operates a rather extensive system of clinic and orthopedic nursing service supplementing that provided locally by public and private agencies, chiefly the latter. The clinics operated by the State Health Department in 1944 held 296 sessions in the 101 communities shown in Figure 5. These clinics, which have the purpose of providing after-care to patients suffering from poliomyelitis and other crippling conditions are primarily consultation clinics and, with few exceptions, receive only patients referred by physicians. Because many of the clinics are held in rural areas they make expert consultation service available to physicians remote from medical centers. In 1944, there were 9,174 visits by 7,064 patients. The cost of these clinics is not available; \$11,730 paid in salaries to orthopedic surgeons who conducted them is exclusive of salaries of members of the Department's staff. No data are available on the few public clinics operated by local agencies, nor on the physical therapy units operated in conjunction with public schools in three areas as demonstration projects. In addition to orthopedic consultations in clinics, individual consultations for emergency orthopedic conditions and for patients with conditions requiring plastic surgery were authorized at a cost of \$1,064.

Orthopedic nursing. Outside of New York City, a special nursing program for crippled children is maintained by the State Department of Health, whose nurses in 1944 made 20,023 visits to 6,639 patients. Although \$60,000 was budgeted for salaries for State orthopedic nurses in 1944, only \$46,866 was spent, because of lack of sufficient qualified personnel. In New York City, orthopedic nursing service is included in the general public health nursing program, and separate service and cost data are not available.

Surgical and hospital care. Court orders for hospital care for the entire State during 1944 totalled \$1,307,770 for 2,997 crippled children and \$41,618 was authorized for 74 adult poliomyelitis cases, as shown in Table 10. The types of cases which were cared for are indicated in Table 11.

New York State Reconstruction Home. This 592 bed institution at West Haverstraw is operated by the State Department of Health for the care of persons who are or are likely to become crippled as a result of disease or injury and who are residents of the State or who were present



Note: Does Not Include Clinics Operated Under Local Auspices
or Physical Therapy Units Operated in Connection With
Public Schools in Three Areas as Demonstration Projects

Table 10. Cost of Care for Physically Handicapped Children and Adult Poliomyelitis Cases, as Approved by the State Commissioner of Health, 1944.

Type of service	Children under 21			Adult polio-myelitis cases ^{b/}
	New York City	Rest of State	Entire State	
Hospitalization	\$607,164	\$608,330	\$1,215,494	\$41,498 ^{c/}
Surgeons' fees	a/	19,325	19,325	120
Miscellaneous	1,750 ^{d/}	71,201	72,951	0
Totale ^{e/}	608,914	698,856	1,307,770	41,618

a/ In New York City, patients are admitted to hospitals as staff cases and a special surgical fee is not authorized.

b/ In 1944, procedure for handling this type of case had not been developed for New York City. Thus, data are for rest of State only.

c/ Includes orthopedic appliances and equipment.

d/ This figure is low because the New York City Court in 1944 did not allow charges for extra services, such as use of operating room, anesthesia, use of room for applying plaster casts, etc. for hospitalized cases, as did the Children's Courts for the rest of the State. Also, New York City obtains appliances at a lower rate than does the rest of the State.

e/ With the exception of an estimated 11 per cent of the cost paid by parents or hospital insurance, the total cost is shared equally by the State and local governments. The amount of care authorized by the court orders is not always obtained in the year in which it is authorized. For example, while \$1,307,770 was authorized for crippled children in 1944, bills in the amount of \$609,780 only were approved during the year. Also, some of the treatment approved may not be obtained.

Table 11. Types of Cases for Which Orders were Issued and Approved by the State Commissioner of Health, 1944

Type of case	New York City		Rest of State		Entire State	
	Orders	Patients	Orders	Patients	Orders	Patients
Children under 21	1,303	1,290	1,762	1,707	3,065	2,997
Poliomyelitis cases	-	600	-	785	-	1,385
Other	-	690	-	922	-	1,612
Adult polio-myelitis cases	0	0	94	74	94	74
Total	1,303	1,290	1,856	1,781	3,159	3,071

in the State when stricken.^{17/} In-patient services included medical, orthopedic surgery, dental care, nursing, physical therapy, occupational therapy, vocational guidance, educational and social service. 447 patients were admitted during 1944 and the average occupancy was 169, or 32 per cent. Bi-weekly out-patient clinic sessions provided treatment, diagnostic and consultative services to 259 individuals who made 592 visits.^{18/} The daily per capita cost of operation was \$7.83,^{19/} with total expendi-

^{17/} New York City is served by this institution on the same basis as is the rest of the State. In 1944, approximately one-half of the patients admitted to the Reconstruction Home were New York City residents.

^{18/} Data on these clinic sessions are included in Figure 5 and in the earlier discussion of orthopedic clinics operated by the State.

tures reaching \$540,011. Of this, patients paid \$29,085, counties were billed for \$89,742 and the State paid the remaining \$421,184.^{20/}

The State Health Department reports that:

The New York State Reconstruction Home is noted for its exceptional physical plant and physical therapy facilities. In the past, services of the institution have been limited to patients under 21 years of age but this limitation was removed by a 1945 amendment to the legislation.^{21/} The usefulness of the institution has also been limited during the war because of the scarcity of qualified personnel, but plans are under consideration to develop the institution in the field of medical and social rehabilitation as soon as conditions will permit.

Summary of costs. The costs of the entire program, and the sources of funds, are summarized in Table 12. These data do not include some of the administrative costs for orthopedic nursing and clinics, and in some instances figures have been included for positions budgeted for, but not filled during the year. All costs of the New York State Reconstruction Home are included, but not the cost of locally-sponsored public orthopedic clinics.

In appraising the service rendered, the New York State Health Department made the following comments:

The Medical Rehabilitation program at present is, through the decentralization of the program into the district offices, undertaking to provide supervision to insure that every patient with a condition falling within the scope of the program is located and once located is provided an opportunity for adequate medical service for diagnosis and therapy. In addition, the Department has the further responsibility for referring the patient to the proper agencies for educational, vocational and social rehabilitation.

A major deficiency in the program is the omission of services for various handicapping conditions such as patients with cerebral palsy, hearing defects, visual defects, convulsive disorders, severe allergy, disturbances of metabolism and cardiac conditions. While tentative programs are being formulated for cerebral palsy, hearing defects and cardiac defects, they have not been developed beyond small demonstrations or minimal services under much too limited facilities. Another deficiency in the services provided by the program is the lack of complete diagnostic services which should include pediatric supervision and laboratory services. While some funds are available for the provision of these services, the lack of trained personnel makes it difficult at this time to insure a complete diagnostic service. The Department is also aware of opportunity for some improvement in the services given in hospitals and convalescent homes. It is felt that

^{20/} There is some duplication between the figures on the total cost to the State of the Reconstruction Home and the cost of care given on court orders, since 90 per cent of all patients at the Reconstruction Home receive care under court orders. The State bills counties at \$3 per day, but reimburses the counties at \$1.50 per day for care approved by the State Commissioner of Health.

^{21/} Public Health Law, Section 352.

Table 12. Cost of the Medical Rehabilitation Program, and Source of Funds.

Cost and source of funds	New York City	Rest of State	Entire State
Cost of medical rehabilitation			
Total	\$834,403	\$1,085,475	\$1,919,878
Source of funds			
Private ^{a/}	37,009	21,470	58,479
Public			
Federal ^{b/}	43,730	134,028	177,758
State ^{c/}	459,193	577,494	1,036,687
Local ^{d/}	294,471	352,483	646,954
Total	797,394	1,064,005	1,861,399
Total	834,403	1,085,475	1,919,878

a/ Includes payments by patients or hospitalization insurance for service rendered on court orders.

b/ Fiscal year 1945-46. Includes salary items and services.

c/ Fiscal year 1945-46 for salary items and services. 1944 costs of service rendered on court orders.

d/ 1944 costs of service rendered on court orders.

Note: This table does not represent the amount spent but rather the amount budgeted for administration, field personnel, etc., and the amount authorized for State-aid on court orders and on adult poliomyelitis cases. For example, in New York City it includes the \$50,304 budgeted for the Division of Physically Handicapped Children, which operates one orthopedic classification clinic and which coordinates and administers the physically-handicapped children's program in New York City.

by paying the hospitals on a cost accounting basis instead of the flat per diem rate which is at present in effect, it will be possible to effect higher standards including the provision of adequate medical social service, more complete medical records, expert nutritional services through the employment of trained dieticians and the availability of occupational and recreational therapy.

Considerable attention has been focused in the past upon the medical care available through surgeons and hospitals. More attention should now be paid to the provision of adequate outpatient treatment and special treatment and special treatment centers located in schools, and foster or boarding home care. While the policy of the Department limits the responsibility of the program to patients with remediable conditions, it is impossible to escape the impact of the large number of patients in need of custodial care and the serious lack of facilities for the provision of such care.

The New York City Health Department states that:

There are many children in New York City who do not get the advantage of a careful diagnosis for their orthopedic or other physical defects. The facilities for actual care are probably adequate.

Vocational Rehabilitation

The purpose of vocational rehabilitation is to make it possible for physically and mentally disabled persons to be medically treated to remove or minimize the handicapping condition and to be so trained as to be employed at the maximum skill consistent with any remaining handicap.

Very often the result is that a disabled person is able to leave the re-

lief rolls for the payrolls of industry and assume the status of a self-supporting member of his community.

New York State has had a vocational rehabilitation program for more than 25 years, financed by State funds and matching Federal funds. Until recently it was chiefly a program which emphasized the training of disabled persons to work in spite of their handicaps and, although some prosthetic devices such as artificial limbs were supplied, few medical services were offered for the purpose of relieving the disability itself. With the passage of the Bardonia-Follette Act in 1943 (Public Laws 113, 78th Congress), Federal funds became available to include services to certain types of disabilities which formerly could not be served, and for a program of physical restoration including medical and surgical treatment and hospital care for the purpose of partially or wholly correcting a condition which constituted a handicap to employment.

No census of the physically handicapped has ever been taken, but if New York State bears the same ratio to the nation's disabled as it does to the nation's population, it has the problem of more than one and a half million persons in the age group 15-64 years disabled to some degree. Of these, possibly 150,000 to 225,000 are seeking work, but require some form of rehabilitation process before they can be placed at work.^{22/} Amendments to the New York State Law^{23/} in 1944 and 1945 extended medical and training benefits to all handicapped persons irrespective of the nature of the handicap, and provided additional funds and personnel for this work. The following data apply to the program of the Division of Vocational Rehabilitation, State Department of Education. A similar program for the blind is administered by the Division of Vocational Rehabilitation for the Blind, State Department of Social Welfare. The Division of Vocational Rehabilitation enjoys the cooperation of other State agencies in the referral of persons who may be eligible for benefits provided under this program. The Workmen's Compensation Board, the Department of Health (and through it, private and public hospitals, clinics and practicing physicians), and the Department of Labor, have regular channels through which handicapped persons are referred to the rehabilitation authorities. The State program conforms to conditions established by the United States Office of Vocational Rehabilitation, Federal Security

^{22/} Estimated on basis of figures in Aid to the Physically Handicapped, Report of the Subcommittee to Investigate Aid to the Physically Handicapped, Committee on Labor, House Report No. 2077, 78th Congress.

^{23/} Vocational Rehabilitation of the Handicapped, Article 47, State Education Law.

Agency, as a prerequisite to Federal grants of 100 per cent of the cost of administration and 50 per cent of the cost of service.

Eligibility. Services are available to all physically or mentally handicapped persons who may be rendered fit for employment or for more suitable employment, and who require financial aid (liberally interpreted) to obtain needed medical services.^{24/} The handicap must be an impediment to the individual's occupational performance, must be relatively non-progressive and of such type that it can be removed or remedied sufficiently to make the person employable within a reasonable period of time. Persons under 14 years of age, the aged or helpless who require custodial care, inmates of mental or penal institutions, and persons considered not susceptible of rehabilitation because of the nature of the handicap, are excluded.

Services. The services available are defined by law only in general terms, more detailed descriptions being provided through administrative regulation. The services available to date include:

Medical examination to determine eligibility, general medical examination and, when necessary, laboratory work, specialist examinations and hospitalization for diagnosis and appraisal (for not more than three days without special approval, and limited to a maximum of ten days).

Medical treatment by general practitioner or specialist.

Nursing service rendered by a graduate nurse, public health nurse, or licensed practical nurse (the latter must be supervised by a graduate nurse).

Hospitalization up to 90 days. Cases requiring slightly over 90 days may be accepted if the patient can arrange for payment of costs after 90 days. An additional 90 days is available for treatment of new disabilities arising subsequent to hospitalization for the original disability. Only hospitals approved by the American College of Surgeons, and the Council on Medical Education and Hospitals of the American Medical Association, may be used.

Dentistry.

Drugs and supplies.

Prosthetic devices.

Physical therapy rendered by a graduate of an approved school or a person registered with the American Registry of Therapy Technicians.

Convalescent and nursing home care for periods of from two to four weeks, in homes meeting satisfactory standards.

The patient is given freedom of choice of facilities among those approved in connection with the program. Medical diagnosis and treatment may be given by all physicians licensed in the State. Specialist service

^{24/} The State Vocational Rehabilitation Law "does not contain any requirement that the client's need for financial assistance be established. However, we are following the practice of determining financial need because, unless we do so, we cannot secure reimbursement of 50 per cent of the costs from Federal funds" - G. S. Bohlin, Director, Division of Vocational Rehabilitation, June 15, 1945.

may be given only by specialists on a roster of physicians recommended by the county medical societies and approved by the State Commissioner of Health; county medical society recommendations are based on certification by the American Medical Specialties Boards or on evidence of experience and training.

Payment for services. A fee schedule similar to the Workmen's Compensation fee schedule is employed for remuneration of physicians, nurses, dentists, physical therapists and other medical personnel. The schedule of rates of payment to hospitals under the Emergency Maternity and Infant Care program has been adopted.

The financial status of the patient is considered in arranging for payment for service. In most instances the Rehabilitation Division makes the entire payment, but in some cases a portion of the costs may be borne by another agency or by the individual or his family. In no case may the total payment for the services, regardless of who makes the payment, exceed the rates set by the fee schedules.

Financing. The Federal government reimburses the State for 50 per cent of all medical costs (providing the fee schedule is not in excess of Workmen's Compensation or other schedules for medical programs under State supervision), and for all administrative costs (not including capital expenditures on building and land). State funds finance the remainder of the program.

Administration. The State Board of Vocational Education^{25/} governs the administration of the program, obtaining technical advice from a Professional Advisory Committee^{26/}, appointed by the Executive Officer of the Board on the recommendations of the Director of the Division of Vocational Rehabilitation, of representatives of public health, the State Medical Society, industrial medicine, the State Hospital Association, and specialists in orthopedics, ophthalmology, otology, cardiology, tuberculosis and psychiatry, and, if available, representatives of the fields of social work, and occupational and physical therapy. The selection of members, made after consultations with professional groups, is based on their recognized leadership or official connections in their particular fields of medicine. The Advisory Committee is responsible for advising on general policies, setting of standards, selection of rates, method of payment for services and other matters brought to its attention; it has no administra-

^{25/} The State Board of Regents is ex-officio the State Board of Vocational Education.

^{26/} The same committee serves as the Advisory Committee to the Department of Social Welfare program for rehabilitation of the blind.

tive authority. The United States Office of Vocational Rehabilitation, in addition to approving the State rehabilitation program for purpose of Federal grants, also offers technical assistance and services to the State.

Operation and potentialities of the program. To date, little surgical, medical and hospital care has been provided, since the enabling legislation is relatively recent, the State plan for operations has only recently been approved in its entirety by the Federal government, and medical personnel to direct the program is difficult to obtain at this time.

During the year ended June 30, 1945, the Division of Vocational Rehabilitation closed as rehabilitated 2,131 cases of all types at a per capita cost of \$258.41, but there is no information available at this time on the per capita cost for medical care only. At the close of the year the Division had 4,777 active cases. During the year 126 persons had been provided with medical services and 233 had received artificial appliances. (In the year ended June 30, 1944, artificial appliances were furnished to 505 persons at a total cost of \$9,936.28, of which \$4,461.53 was subsequently refunded by the persons receiving appliances).^{27/} Of 2,110 classified cases, the disability of 555 was incurred in employment, 226 were disabled by other accidents, 315 by congenital defects, 132 were infantile paralysis cases, 642 had been handicapped by other diseases, and 140 had been injured in military or naval service. The accomplishments of the program are indicated by the fact that of 2,564 cases rehabilitated in 1943-44, a survey made in 1944-45 showed 87.3 per cent to be employed.

These and other data available provide little indication of the potential use of the medical services, because the program is of recent origin, it has not been widely publicized, and precise information is lacking on the number of disabled persons and their physical rehabilitation needs. However, it seems certain that if all persons who are eligible to benefit by the rather liberal provisions of this law were to take advantage of it, a very large medical program would result. If a medical insurance program were adopted by the State, there would be overlapping of its benefits and those that would be available under the rehabilitation program. To ensure continuation of receipt of Federal moneys by the State and to avoid duplication of effort, it would seem desirable for the Division of Vocational Rehabilitation to continue to provide its clients with medical care, but to do so through the State medical insurance administration and to make suitable payments therefore from vocational rehabilitation funds.

^{27/} Annual Report, 1944, Division of Vocational Rehabilitation, New York State Education Department.

Public Health Nursing

Public health nursing is an organized community resource for furthering public health measures designed to prevent and reduce sickness and to produce positive health....the contribution of the public health nurse is essentially educational, whether her service is given in the form of nursing care to the sick or health guidance and instruction to the sick and well, whether she works in home, health center, clinic, school or industrial plant; whether she is employed by a governmental or voluntary, health or non-health agency.^{28/}

In 1877, the first systematically organized nursing service in America given by trained nurses outside of hospitals was initiated by the Women's Branch of the New York City Mission. Municipal nursing was begun in New York City in 1902, when the Health Department engaged nurses for home care of selected cases. In the following years, many cities upstate followed suit. The State of New York entered the public health nursing field in 1913, when the State Commissioner of Health was authorized to employ public health nurses. Subsequent legislation created a Division of Public Health Nursing in the State Department of Health^{29/}, provided for State aid to counties for public health nurses^{30/}, and authorized the employment of public health nurses by local health officers.^{31/}

Community public health nursing work is carried on by official agencies such as boards of health, and by non-official agencies such as visiting nurse associations, the American Red Cross, insurance companies,^{32/} etc. The same community may be served by both an official and a non-official agency. In such instances, there is generally an agreement to avoid duplication of work. Usually the department of health nursing services are largely confined to education and demonstration, i.e., providing some nursing care directly but emphasizing the teaching of a member of the household to continue the care of the patient, while the non-official nursing agencies tend to place more emphasis on rendering nursing service directly to patients.

New York State, exclusive of New York City. The State Department of Health supervises the work of its own and of public health nurses employed by counties, cities and townships, through its district offices. It also

^{28/} "Public Health Nursing Program and Functions" Public Health Nursing, June 1944.

^{29/} Public Health Law, Section 3-a.

^{30/} Ibid. Section 19.

^{31/} Ibid. Section 21c and County Law, Section 12, Subdivision 44-a.

^{32/} Some types of contracts of the Metropolitan Life Insurance Company and the John Hancock Insurance Company include home visiting nursing service, which may be provided by company nurses or through contract with non-official nursing organizations in the community.

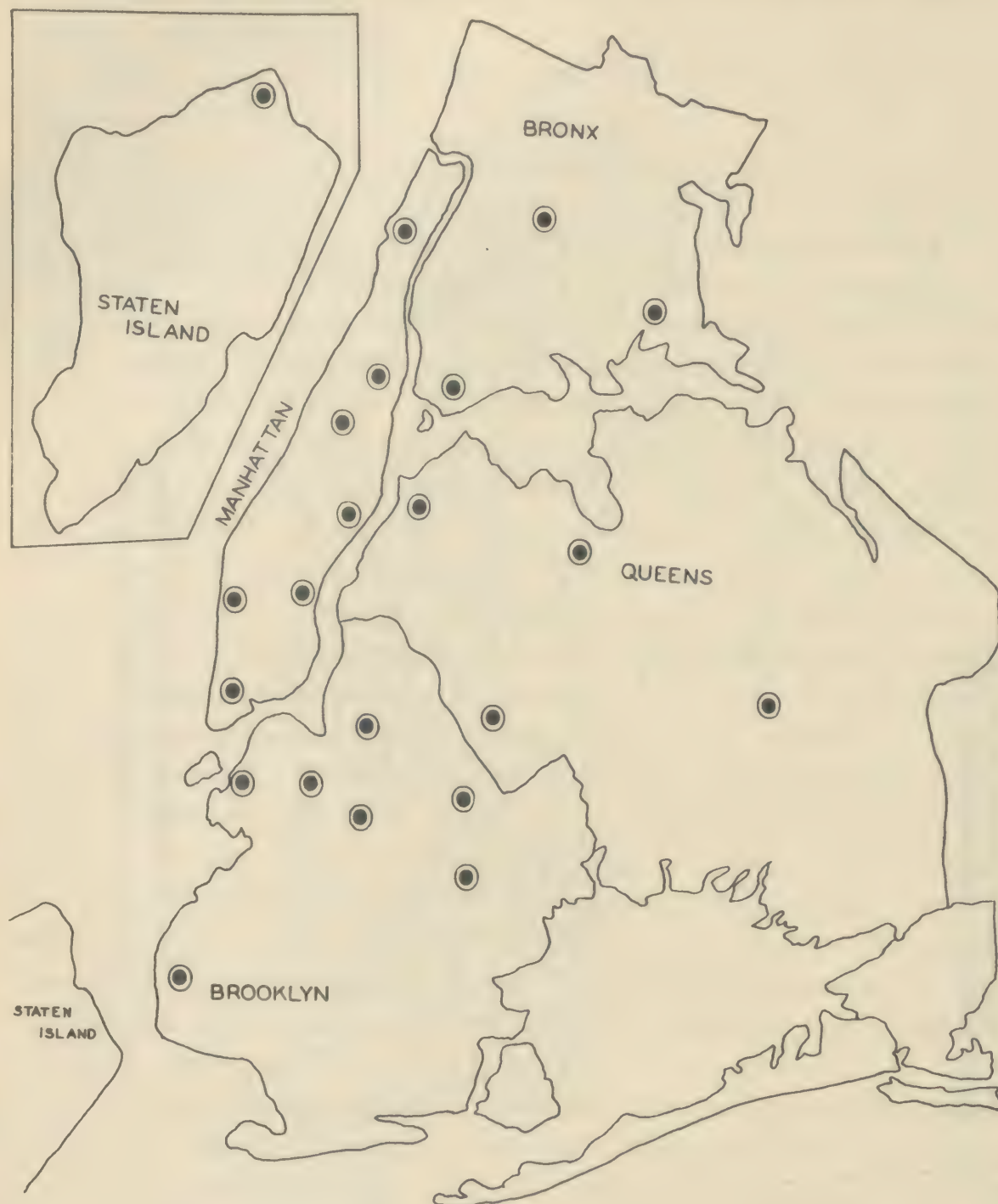
assigns nurses on its staff to work for specified periods as county nurses in order to provide more adequate local service and to demonstrate to localities the value of public health nursing service. Other activities of the State Health Department include a State-wide training program for public health nurses, and the assignment of nurses to districts for special types of public health work.

County, town and village nurses routinely engage in a generalized service, performing all types of nursing service in a given area to avoid duplication of service by various types of nurses. This service usually includes nursing care of the sick at the bedside, from 15 to 50 per cent of visits in rural areas being of this type, the percentage tending to increase in rural areas as the number of nurses per unit of population increases. Nursing is provided for those schools not served by specialized school nurses. Physicians, officials or private individuals may initiate a call for nursing service. The nurse works under the authority of the health officer in rendering the services included in the preventive community health program (communicable disease, tuberculosis, syphilis control, etc.), under the superintendent of schools and school medical officer for work in the schools, and under the orders of the attending physician if sickness is involved. Nursing care of the sick in the home is given at the bedside in the form of visits which usually do not exceed an hour in length. The objective of the visit is to teach the home attendant to give nursing care pursuant to physician's orders. However, if the patient is critically ill or if certain treatments requiring highly skilled care are required, the nurse may make any number of return visits. Obviously, the size of the territory covered by the nurse and the population served is the factor which limits the amount of nursing care of the sick which can be given by a community nurse, it being considered that her first responsibility is the preventive work of the health department. No fees are charged for nursing care of the sick since the service is chiefly educational in nature.

City public health nurses ordinarily include no bedside care in their work, since this is for the most part handled by non-official visiting nurse associations.

The volume and cost of nursing service are indicated in Table 13 and Figure 6. No attempt should be made to compare the cost per visit of the official public health nurse with the cost per visit of the nurse employed by a visiting nursing association to give bedside care because the content of the visits is usually entirely different. The former may entail a

FIGURE 7. LOCATION OF NURSING OFFICES OF THE NEW YORK CITY DEPARTMENT OF HEALTH, 1945



lecture or demonstration, or a communicable disease investigation, whereas the nursing visit for bedside care is usually limited as to time, perhaps 30 to 45 minutes.^{33/} The rest of the State enjoys a much greater volume of public health nursing service than does New York City. Not only are visits other than bedside nursing care nearly twice as great outside of New York City, but the figures for the rest of the State do not include the visits made by about 700 nurses employed by school districts. (A detailed description of the number, type and location of all nurses visiting in the home is given in the chapter on facilities). The amount of bedside nursing care given by official public health nurses is somewhat more than 92,000 visits, and for purposes of this study has been arbitrarily estimated to have a dollar value of about \$150,000.

In appraising its public health nursing service, the State Health Department stated that:

The employment by the state of supplementary nurses to assist public health nurses in giving sickness care has been an excellent experience and one that should be helpful for the future if a more comprehensive sickness care program is promoted....

The nursing service which coordinates state and local facilities has demonstrated its adequacy in plan and scope of program. The county as a basis for employment of nurses provides a workable unit and a more mobile group of workers to meet the needs of the jurisdiction. Care of the sick on a visit basis has been demonstrated as a feasible and valuable part of a community public health nursing service. The assignment of state paid nurses to become part of a local unit has proved an excellent method to encourage the employment of local nurses. The training of nurses as a state project has proved an effective method of providing a reservoir of competent nurses for local civil service.

The inadequacy is related to the fact that far too few nurses are employed and many areas are poorly served.

Home nursing of the sick on an organized State-wide basis requires a full time public health nurse for all areas of the State. One public health nurse for every 2500 to 3500 people would be the minimum with the additional employment of part-time licensed nurses during the peak periods of illness. It is recommended that the Commission work with the State Department of Health to consider the best method to provide the coverage of the State with nursing service adequate to meet the needs of the health departments and home nursing for the sick. Such a plan might be advanced independent of a comprehensive medical care plan since it serves a double purpose. It would fit into a pattern already accepted and is a necessary service to make home nursing effective under any state-wide insurance system.

^{33/} It should be appreciated that one or two fairly lengthy visits to the home to demonstrate to a member of the household the proper care of the sick may relieve the family or community of the necessity of making expenditures for repeated visits by nurses who simply provide service without teaching.

Table 13. Nursing Visits and Cost of Public Health Nursing Service Provided by Local Health Departments and County Boards of Supervisors, with or without State Aid; and by State Health Department Supervisory Nurses and Field Nurses Assigned to Cities or Counties, 1944.

	New York City ^{b/}	Rest of State ^{a/}	Entire State
Number of public health nurses			
State supervisory ^{f/}	0	80	80
State-assigned	0	44	44
State-aid local	0	271	271
Other local	818	331 ^{d/e/}	1,149
Total	818	726	1,544
Nursing visits			
Bedside	0	92,601	92,601
Other	329,867 ^{c/}	595,605	925,472
Total	329,867	688,206	1,018,073
Cost of service and source of funds			
Federal	\$ 76,097	\$ 193,246	\$ 269,343
State	0	536,704	536,704
Local	1,750,364	1,081,406	2,831,770
All public	1,826,461	1,811,356	3,637,817
Private	0	5,315	5,315
Total	1,826,461	1,816,671	3,643,132

Note: The data from which these figures have been compiled do not in many instances include complete operation and maintenance costs because public buildings are often used for quarters. Further, operational and clerical expenditures of the State District Health Offices are not included. Thus, data are not applicable for a cost per visit analysis.

^{a/} Includes 3 U. S. Public Health Service nurses on loan to the New York State Health Department. Figures for 1944.

^{b/} Service figures for 1944, cost figures for fiscal year ending June 30, 1944. Budget for year ending June 30, 1945 was \$2,138,007, but many positions were not filled. Of the 818 nurses, 310 are engaged as school health nurses.

^{c/} Including 238,505 home and 91,362 other.

^{d/} No data are available on types of nurses in Yonkers; thus the 19 nurses for Yonkers are all included under this category.

^{e/} For Buffalo, only Child Hygiene Division nurses are included. Public health nurses connected with the Divisions of Syphilis Control and Tuberculosis are not included.

^{f/} These are the State Health Department, Division of Nursing, supervisory nurses whose services cost a total of \$250,000 for the year, of which \$122,400 was paid from Federal funds, and the remaining \$127,600 was paid from State funds.

New York City. In New York City, public health nursing service is supplied by the City Health Department to the elementary, parochial, public and vocational high schools of the city and to Health Department clinics. In type, it includes visits to the homes of school children, pre-natal cases, well babies, midwives, communicable disease, tuberculosis and venereal disease patients, and visits to foster homes as well as school nursing duties, in which 310 nurses are engaged. The function of the nurse is primarily educational, to teach the principles of health conservation and disease prevention, and the need for medical supervision. The New

York City Health Department comments on this service, that:

The adequacy of the service has been somewhat hampered by the unprecedented turnover of personnel which has occurred during the past two years, due to retirements, resignations, and leaves of absence granted to nurses entering the armed forces....

There is evident need for an expansion of the Health Department nursing services, for instance, in the academic high schools, in industry, and in day care service. More responsibility could be assumed in the visiting of the new-born, and giving assistance to the foster home service....

However, it is felt that the services have been well taken care of, even if not adequately covered at all times.

Laboratory Service

The development of public laboratory service is closely associated with the development of medical and public health measures for the diagnosis and control of communicable diseases. Because communicable disease control is a measure for general community protection, the associated laboratory service has from the beginning been largely supported by public funds and available without cost to any person residing in the State if his attending physician chooses to utilize it. However, this is generally true only for the person who is not a patient in a hospital (except a public hospital). Because it is desirable to have laboratory facilities close to the patient, most hospitals have laboratories on the premises and, when they do, the cost of operation is generally included with the general cost of hospital service and the patient is charged for some laboratory services which might be obtained without cost from a public laboratory if he were not a patient in the hospital.

Aside from the hospital patient described, laboratory examinations for communicable and other infectious diseases are usually obtained without charge by the person residing outside of New York City, regardless of his ability to pay; there are very few private laboratories providing this service. In New York City, relatively more of this work is done by private laboratories, of which there are a considerable number.

The growth of public laboratory service has not paralleled that of other public health programs in scope. While other public health activities have ranged beyond the original one of communicable disease control, the public laboratories have adhered quite strictly to their first purpose, although the volume, importance and cost of other types of examinations, such as blood chemistry, electrocardiography, diagnostic radiology, etc., have increased tremendously. Therefore, although the data presented in this section relate to service provided on behalf of individuals, and exclude examinations of milk, water, etc., many of the services are of a

community health protective nature rather than those which would be furnished to private individuals who could afford them.

New York State, exclusive of New York City. The present outstanding system of State and State-approved municipal and non-governmental laboratories serving New York State originated early in the century and developed rapidly after 1913, when the Legislature authorized the State Health Commissioner to establish one or more State laboratories and to contract for service to be provided by laboratories in various parts of the State.^{34/} Ten years later, the Legislature authorized State-aid for county and city-owned laboratories^{35/} (excluding New York City) of up to \$2,500 towards initial installation, and one-half of the annual cost of operation up to \$7,500, provided the charges made by such laboratories were reasonable. Grants are also available, to counties or cities which purchase service from other approved laboratories.

The Division of Laboratories of the State Health Department furnishes laboratory service to physicians and health officers through its Central Laboratory at Albany and Branch Laboratory at New York (but not for New York City); develops and maintains high standards of service in local laboratories^{36/} through a system of approval and inspection, supplies certain diagnostic materials to locally approved laboratories, prepares and distributes antitoxins, sera, vaccines and drugs for the prevention and control of infectious diseases^{37/}; and conducts fundamental research for the development of better standards of laboratory methods.

The State Health Department laboratories at Albany and New York provide a limited service for counties that do not have approved laboratory facilities (see Figures 8 and 9), and do certain tests, such as serologic tests for syphilis, for many areas that have laboratories not equipped to perform them. However, the State laboratories do not usually undertake those examinations which are best done in a local laboratory where there is opportunity for close cooperation between the director of the laboratory and the physician in charge of the patient. They are, however, ready to

^{34/} Public Health Law, Section 4-b.

^{35/} Ibid. Sections 20-c and 20-h.

^{36/} The State Sanitary Code requires that, for the State, excepting New York City, certain examinations be performed in laboratories which have been approved for the purpose by the State Department of Health. Laboratories in New York City wishing to do work for physicians outside of New York City must also secure this approval. The examinations for which approval is required include pathology, and bacteriologic and serologic examinations for evidence of communicable disease.

^{37/} The Department has never made a charge for these products, although until recently it restricted distribution to those persons who were unable to pay.

FIGURE 3. LOCATION OF LABORATORIES APPROVED BY STATE
DEPARTMENT OF HEALTH FOR DIAGNOSTIC EXAMIN-
ATIONS, NEW YORK STATE, 1945

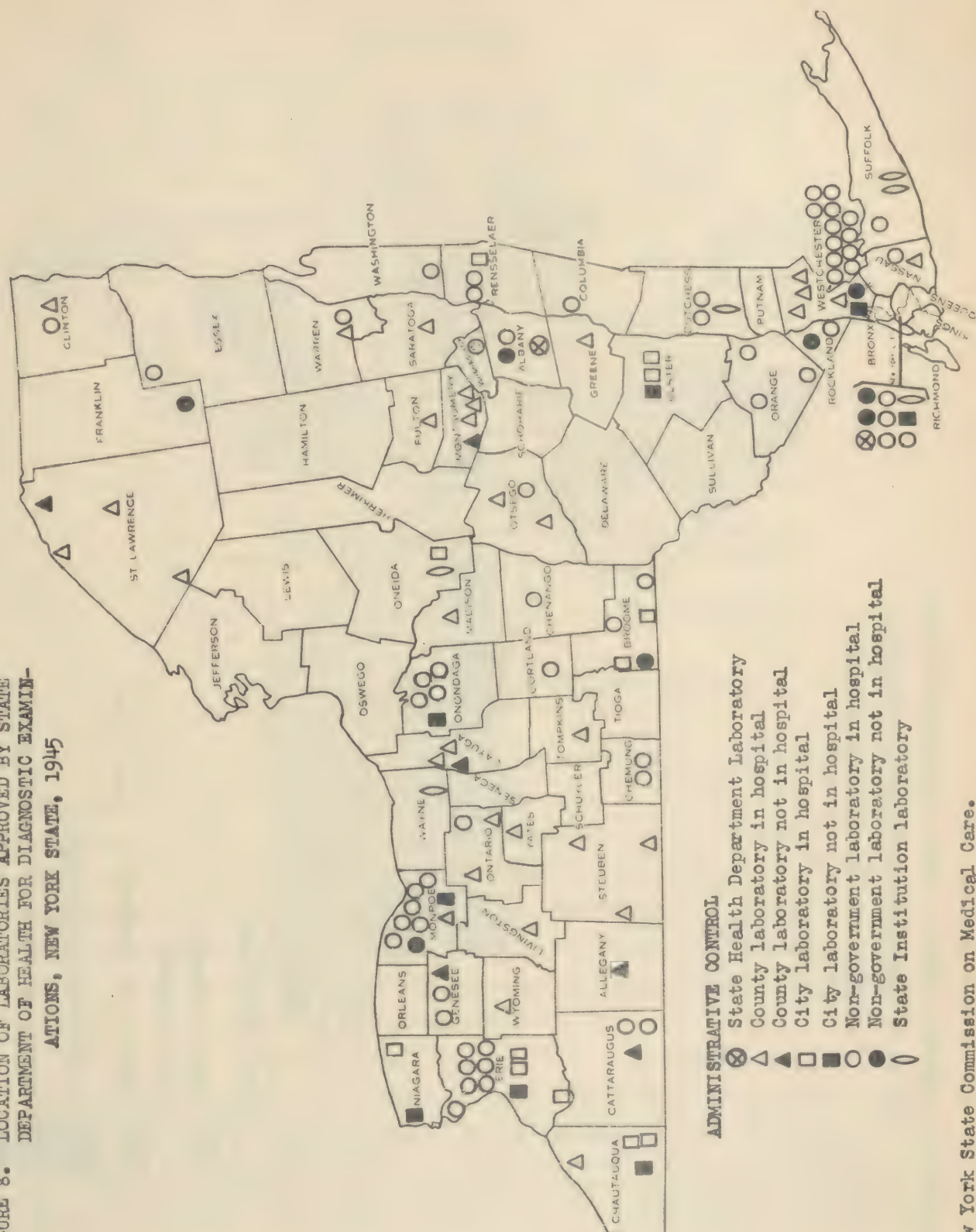


FIGURE 9. COUNTIES SERVED BY PUBLIC LABORATORIES APPROVED
BY STATE DEPARTMENT OF HEALTH FOR DIAGNOSTIC
EXAMINATIONS, NEW YORK STATE, 1945

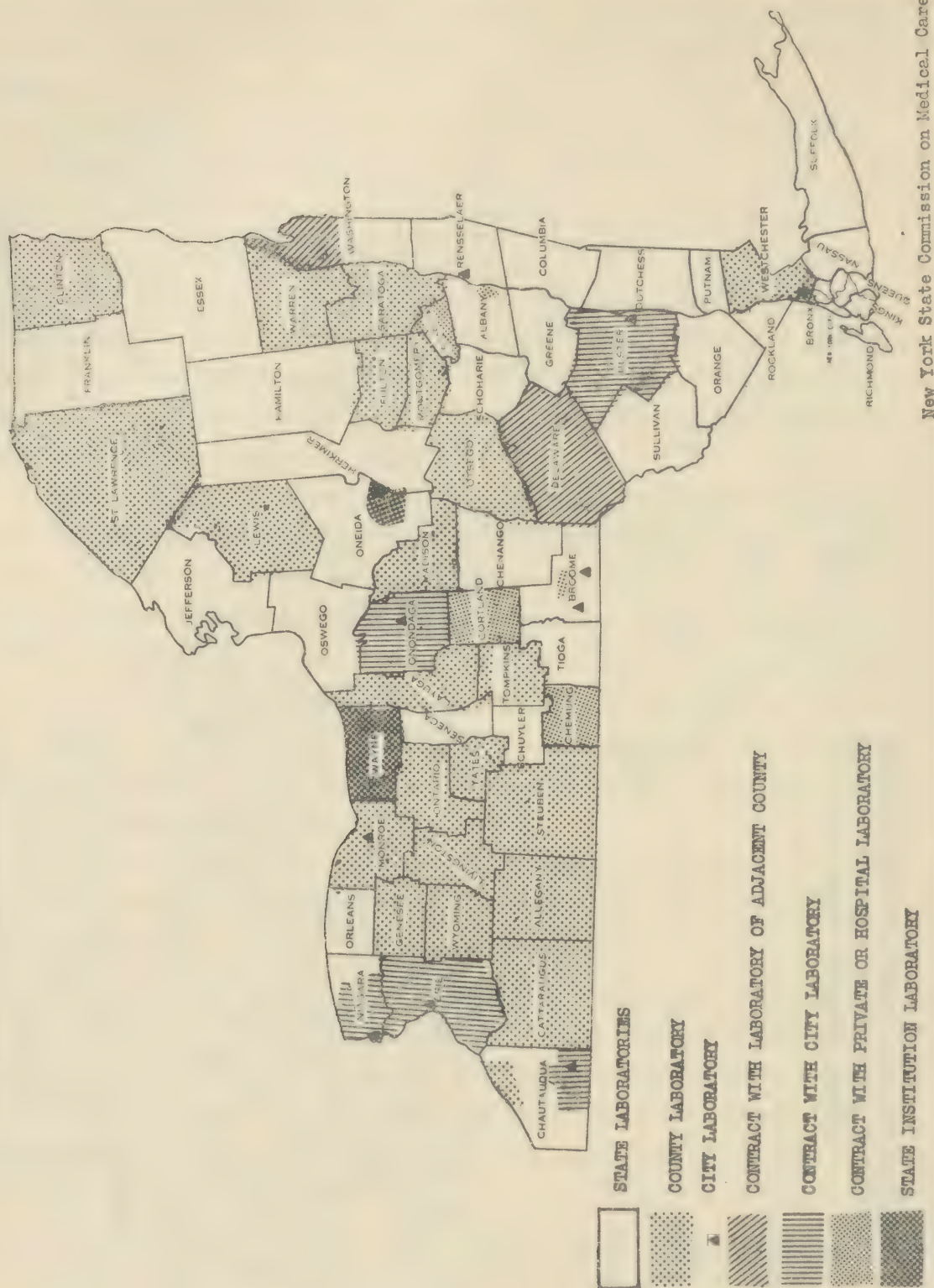


Table 14. Examinations on Behalf of Patients Made by the State Health Department Laboratories, by New York City Health Department Laboratories and by Approved^{a/} Laboratories in Receipt of Public Funds in 1944.

Type of laboratory	Number of examinations ^{b/}
New York City	
City Health Department	816,000
Rest of State	
State Health Department	560,000
Approved laboratories in receipt of public funds	
State-aid ^{c/}	708,000
Others paid from public funds ^{c/d/}	727,000
Total ^{e/}	1,995,000
Entire State	
Total	2,811,000

^{a/} Approved by State Health Commissioner for certain types of examinations.

^{b/} Excluding sanitary examinations. The number of specimens examined is considerably less than the number of examinations. For the State laboratories, about 1.6 examinations per specimen were made and for other laboratories, about 1.1 examinations per specimen.

^{c/} Includes only tests estimated to have been paid for from public funds.

^{d/} Based on survey by Commission.

^{e/} An additional 1,800,000 examinations made by approved laboratories were paid for privately.

assist approved laboratories, and to make confirmatory examinations for physicians and health officers. All work done by the State laboratories is free of charge. The 124 local laboratories approved by the State^{38/} as of July 20, 1945, were located as shown in Figure 8 and covered the areas shown in Figure 9. As to type, the 121 laboratories approved in 1944 included 31 county laboratories, 112 municipal, 61 hospital, 7 in State institutions^{39/}, 1 in an educational institution, and 5 private (in addition to 4 located in New York City.)

The number of examinations, exclusive of milk and water specimens, etc., is shown in Table 14, and the costs are shown in Table 15.^{40/} The

^{38/} In addition, 8 laboratories in New York City secured approval so that they could do work for physicians outside New York City. These include the State branch laboratory, the Brooklyn State Hospital and the City Health Department laboratory, and five private laboratories, see Figure 6. This does not include laboratories authorized to make rabies examinations solely.

^{39/} Not all State institutions' laboratories are approved. Several of those that are approved contract with counties or cities to do laboratory work for them.

^{40/} To obtain the cost of work exclusive of sanitation, twenty-five per cent has been deducted from the total cost on the basis of data for laboratories keeping separate records.

State laboratories made 560,000 examinations which, together with the services rendered to local laboratories in respect to supervision, etc., cost \$850,000. The 37 city and county laboratories in receipt of State-aid made 1,023,000 examinations (708,000 of them estimated to have been paid for from public funds) costing \$467,000, of which \$146,000 was received in private fees^{41/}, and \$145,000 from State and \$176,000 from local public funds. Eleven other approved laboratories made about 727,000 examinations (excluding those paid for privately) for which \$156,000 of public funds was received.^{42/} Outside of New York City, the State and local approved laboratories made in total more than 3.8 million examinations in 1944, of which about 2 million were paid for from public funds at a cost of \$1.3 million.

In addition to the examination of specimens, the State Health Department has arranged for the establishment of 116 district laboratory supply stations and 80 substations to serve the State outside of New York City (see Figure 10). These stations distribute outfits for the submission of specimens to the State laboratories, and supply antitoxins, sera, vaccines, and drugs to physicians throughout the State. All products are supplied without charge, but it is expected that certain products purchased by the State from commercial sources, such as anti-anthrax serum, will be replaced if the patient is able to pay for the material, or if the case is covered by Workmen's Compensation. The cost of the antitoxins, serums, vaccines, sulfonamide drugs, etc. distributed was \$210,600,^{43/} of which only \$920 was paid by the recipients.

In discussing the laboratory system in the State, the State Department of Health comments that:

The primary plan is recommended as highly successful and deserving of support and continuance. It should be supplemented by facilities for the training of local laboratory personnel in the Central Laboratory. Positions for physicians-in-training have been requested

41/ Most of the laboratories do work free of charge. However, in some, moderate fees are charged patients who are able to pay.

42/ Data on these laboratories were obtained by the Commission on Medical Care through a survey of approved laboratories not in receipt of State-aid. The exclusion of costs of sanitation examinations is founded on estimates based on data for the laboratories which were able to supply detailed estimates.

The only data included on laboratories of State institutions are for examinations performed under contract with local public health officials. Other laboratory work of these institutions is included in the data on these institutions contained in the appropriate sections on them.

Work done for welfare patients and paid for by public welfare authorities is not included in these estimates since the cost of this work is included in the cost of medical care paid for by public welfare authorities.

43/ Does not include drugs for the treatment of venereal disease, the cost of which is included in venereal disease control activities.



Table 15. Cost of Operation and Source of Funds for Examinations on Behalf of Patients, New York State and New York City Health Department Laboratories, and Approved Laboratories^{a/} in Receipt of Public Funds in 1944.^{b/}

Type of laboratory	Cost of operation	Source of funds			
		Private	Public		
			Federal	State	Local
New York City ^{d/}					
City Health Department ^{c/ d/}	\$640,364	\$1,200	\$63,830	0	\$575,334
Rest of State					
State Health Department ^{c/ d/}	850,271	0	152,826	\$697,445	0
Approved laboratories in receipt of public funds ^{e/}					
State-aid ^{f/}	467,175	146,112	0	145,500	175,563
Others paid from public funds ^{g/}	156,306	0	0	0	156,306
Total	1,473,752	146,112	152,826	842,945	331,869
Entire State					
Total	2,114,116	147,312	216,656	842,945	907,203

^{a/}Approved by State Health Commissioner.

^{b/}For State laboratories, data are for fiscal year ending March 31, 1945; for City Health Department, for calendar year 1944; for other laboratories, fiscal year usually ends October 31 or December 31, 1944.

^{c/}Includes cost of laboratories, special investigations, administrative offices and general services.

^{d/}Excludes the value of preparations distributed.

^{e/}Includes State-aid laboratories and other laboratories receiving local public funds. Does not include laboratories in State institutions, excepting for that portion of their funds received for work contracted for by local governments, or laboratories of municipal hospitals.

^{f/}One-fourth has been deducted for sanitary examinations. \$186,000 was appropriated for clinical examinations for State-aid laboratories during the period, but only \$145,500 was paid out because of delayed opening of the Westchester County laboratory facilities.

^{g/}Based on survey by the Commission on Medical Care. Cost data are for only 727,000 tests paid for from public funds.

^{h/}Does not include \$800,000 spent for laboratory work in Department of Hospitals laboratories.

for this purpose and to provide a flow of highly trained candidates for directors or other medical positions in the local laboratories, who are thoroughly familiar with the Division's standards and methods. It is also recommended that the expansion of the local laboratory services, both with and without State-aid, be energetically pushed and that steps be taken to extend the scope of various local laboratories so they can cope with the newer responsibilities that advances in knowledge have thrust upon them. Probably a fifty per cent increase in the amount now given in State-aid will be required to complete the organization in New York of a model public health laboratory service. The Division's second responsibility is that of a service organization to the various divisions of the State Department of Health to which it provides laboratory services, acts as consultant in the technical fields each is concerned with, and develops scientific knowledge essential to work of the several divisions. The development of closer collaboration is a major policy of the laboratory and appears to progress rapidly. It is believed of fundamental importance that no Departmental organization be adopted which would interfere with the laboratory's broad obligations to the various

divisions of the Department and to the approved laboratories in New York State.

Comment is made on the cooperation of the Division....

with the personnel of the local laboratories by personal contacts and through the medium of the New York State Association of Public Health Laboratories. This development has contributed great benefits and has become not only a democratic mechanism for joint action on the State level but also a means of effective post-graduate training.

(Concerning approval of laboratories) approval may connote to many persons approval of any type of work undertaken, but at present approval is limited to pathology, bacteriology and serologic examinations for evidence of communicable disease and sanitary examinations. The scope of facilities offered by the approved laboratories should be broad and should keep abreast of the times; for example, at present there is a need for more work relating to mycology, virus infections and nutritional deficiencies. To parallel this comprehensive development, provision should be made for the establishment of standards for all types of laboratory examination and issuance of approval. The examinations not now covered by approval may be broadly classified as clinical-pathologic; they include such examinations as blood counts, chemical studies of the blood, and urine analyses. When there is a demand for approval of laboratories for these types of examinations so as to insure the accuracy of the findings, it is believed that they can be included without changing the law or Sanitary Code.

New York City The Bureau of Laboratories of the City Health Department maintains four laboratories which offer routine diagnostic services to physicians, and bedside consultation and laboratory services in infections of the central nervous system. In addition, patients referred from the Health Department clinics and others who cannot afford a physician may be admitted to the Division of Tropical Disease Diagnostic Service for examination and consultation on request from physicians and hospitals. 400 drug stores designated as district supply stations distribute the Department's biological products, supply physicians with outfits for the collection of specimens, and receive specimens for transmission to the diagnostic laboratory. Specimens left for diagnosis are collected daily at specified times from certain of these drug stores, designated as "collecting stations."

The system of approval of other laboratories by the New York City Department of Health differs from that employed by the State Health Department. The scope is much greater, including chemical and biochemical tests as well as bacteriological, serologic and pathologic examinations. All clinical laboratories except those in municipal hospitals must obtain permits, which are issued for specified groups of tests such as bacteriological, biochemical, chemical, histologic, pathologic and serologic examinations, on the basis of compliance with standards established by the

Bureau of Laboratories. In 1944 there were 276 clinical laboratories under permit, of which 131 were hospital and sanatorium laboratories, 3 industrial and 142 private. Data are not collected by the Health Department on the number or type of examinations, cost of operation or source of funds.

In 1944 the Bureau of Laboratories made 816,443 examinations on behalf of patients. This number is relatively less than for the rest of the State due in part to the fact that many examinations are done in the laboratories of municipal hospitals, and in part to the fact that the private laboratory plays a more important role in New York City than in the rest of the State. The estimated cost of laboratory diagnosis was \$640,364, all but \$1,200 of which was paid from public funds. The City makes no charge to patients. The sources of funds are indicated in Table 15.

In addition to the costs shown, antitoxins, serums, and vaccines and certain drugs costing \$46,946 were distributed,^{44/} of which \$23,314 was returned through sale to patients and other agencies, and \$23,632 was paid from public funds.

The New York City Health Department reports concerning its laboratory service that:

It has been difficult to keep the service up to modern standards. Many skilled workers have left for better opportunities elsewhere and because conditions created by the present war have made it necessary to employ workers with sub-standard qualifications. Positions in the high grades offer no incentive to public health bacteriologists because of lack of opportunity for advancement both in regard to position and salary.

^{44/} Does not include \$12,060 for anti-syphilitic drugs distributed to private physicians during the year. This figure is included in the cost of venereal disease control.

CHAPTER VI

PUBLIC MEDICAL CARE, CONTINUED

(TUBERCULOSIS, VENEREAL DISEASE, CANCER, MENTAL HOSPITALS)

Tuberculosis

Tuberculosis is one of the most formidable diseases which has confronted mankind. Although more prevalent among the lower income groups, it is a communicable disease which does not spare any class, and for

Table 1. Tuberculosis Deaths, All Forms, per 100,000 Population, New York State, 1900-1944.^{1/}

Year	Mortality per 100,000 ^{a/}		
	New York City	Rest of State	Entire State
1900	279	162	217
1905	234	155	195
1910	211	144	179
1915	196	132	166
1920	126	112	120
1925	87	89	88
1930	81	56	70
1935	67	42	56
1940	54	34	45
1944	52	33	43

^{a/} Recorded rate 1900-25; resident rate 1930-44.

this reason the diagnosis and care which are incident to its control have long been an almost completely public responsibility. A gratifying decrease in the mortality rate has occurred since the turn of the century, but the rate of decline is not so great as in earlier years. More than any other disease, tuberculosis takes its toll of death and disability among young adults and the resulting invalidism and broken homes burden the community with a cost far greater than the amount spent for prevention and direct care of patients.

Public acceptance of the responsibility for prevention and treatment of tuberculosis dates back to the pioneering efforts of the New York City Board of Health in 1887, when it ordered an investigation into the cause and prevention of pulmonary tuberculosis. New York City took the lead in establishing in 1902 the first dispensary for pulmonary tuberculosis and appears to have founded the first municipal hospital for tuberculosis in the United States. In the same year, the State authorized the establishment of the Raybrook State Sanatorium for incipient tuberculosis cases. The State Legislature in 1909 authorized the counties to establish hospitals for treatment of tuberculosis of all stages, and eight years later made such construction compulsory for counties with a population of more than 35,000, unless the counties had contracted for the care of tuberculosis patients in a county hospital of an adjoining county or with a private hospital in the same county.^{2/}

^{1/} From annual reports of the New York State Department of Health.

^{2/} County Law, Section 45.

The tuberculosis control program aims to reduce the number of tuberculosis deaths and cases, and prevent the spread of tuberculous infection. This requires the reporting and registration of cases, case-finding, medical care and hospitalization, public health nursing, social service, education, rehabilitation and research, of which only care and hospitalization are within the scope of this study. Because the medical care and hospitalization of tuberculosis cases require highly specialized personnel and facilities, and because they are inseparable from the other public health functions described, they have almost always been excluded from medical insurance programs.

New York State exclusive of New York City. The responsibility for formulation of policies and general supervision of tuberculosis control activities rests with the Division of Tuberculosis of the State Department of Health. The field program is under the direction of the Division of Local Health Administration and its twenty district State health offices, and the Division of Public Health Nursing, in cooperation with tuberculosis hospitals. These comprise four district State tuberculosis hospitals covering thirty counties,^{3/} and county or city tuberculosis hospitals in twenty-six counties of the State.^{4/} The State hospital at Raybrook also has a separate division which may receive, without charge, incipient cases from any part of the State. The facilities and services of these public

^{3/} Set up under the Public Health Law, Sections 335-343 and 350-368. They are the Hermann M. Biggs Memorial Hospital at Ithaca, the Homer Folks Tuberculosis Hospital at Oneonta, the Mt. Morris Tuberculosis Hospital at Mt. Morris, and the New York State Hospital for Incipient Tuberculosis at Raybrook (see Figure 1).

^{4/} Set up under the County Law, Sections 45 - 49-e and the General Municipal Law, Sections 125 - 135-b. The county and city hospitals are the Broome County Tuberculosis Hospital, J. N. Adam Memorial Hospital (Buffalo), Rocky Crest Sanatorium (Cattaraugus County), Newton Memorial Hospital (Chautauqua County), Chemung County Sanatorium, Chenango County Tuberculosis Hospital, Columbia County Tuberculosis Hospital, Samuel W. Bowne Memorial Hospital (Dutchess County), Pine Crest Sanatorium (Herkimer County), Jefferson County Sanatorium, Iola Sanatorium (Monroe County), Montgomery County Tuberculosis Hospital, Nassau County Tuberculosis Hospital, Niagara Sanatorium, Oneida County Tuberculosis Hospital, Onondaga County Tuberculosis Hospital, E. & W. C. O'Dell Memorial Sanatorium (Orange County), Oswego County Tuberculosis Hospital, Pawling Sanatorium (Rensselaer County), Summit Park Sanatorium (Rockland County), Saratoga County Tuberculosis Hospital, Schenectady County Tuberculosis Hospital, Suffolk County Tuberculosis Hospital, Ulster County Tuberculosis Hospital, Westmount Sanatorium (Warren County), Gray Oaks Hospital (Yonkers).

The City of Buffalo also has a large tuberculosis division in the E. J. Myer Memorial (City) Hospital. Westchester County has a tuberculosis division in the county general hospital, Grasslands Hospital.

Albany County has no county or city tuberculosis hospital, care being given in a special tuberculosis section of a private hospital under contract with the county.

institutions are indicated in Table 2, and their location is shown in Figure 1. In a few cases, services are supplemented by the direct assistance of non-official agencies.

All State residents needing care are eligible for admission to State hospitals, with preference given to patients who cannot afford to pay for care in private institutions and who come from counties designated by the State Health Commissioner to be served by the hospital (see Figure 1). Payment for those persons who cannot pay for themselves is made on a per diem basis by the county of the patient's residence. However, admission to State hospitals of residents of counties served by county institutions is by law permissible only upon the request of the superintendent of the county institution, and such request is usually made only for cases needing special surgery. County hospitals must accept residents of the county,

Table 2. Services Provided by Public Tuberculosis Hospitals in New York State, Exclusive of Veterans Hospitals.^{a/}

Public tuberculosis hospitals	Hospitals	Beds	Patients under care	Patient days	Average census	Per cent occupancy	Average stay (days)
New York City ^{b/}							
Tuberculosis hospitals	3	2,751	2,607	901,288	2,469	89.7	161
Provisional facilities ^{c/}	7	1,474	5,863	324,343	887	c/	55 ^{c/}
Total	10	4,225	11,470	1,225,631	3,356	c/	c/
Rest of State ^{d/}							
State ^{e/} City and county ^{f/}	4	1,134	1,769	315,395	864	76.2	178
	28	3,930	7,151	1,219,935	3,342	85.0	171
Total	32	5,064	8,920	1,535,330	4,206	83.1	172
Entire State							
Total	42	9,289	20,390	2,760,961	7,562	c/	c/

a/ About 350,000 days care were provided in veterans hospitals in 1945.

b/ Data for 1944. Does not include about 300,000 days care in private hospitals at New York City expense.

c/ 484 of these beds were available for only part of the year. They are used for tuberculosis patients for diagnosis and pending admission to a sanatorium. Per cent occupancy and average length of stay were not computed for this reason.

d/ Includes estimates for tuberculosis facilities of E. J. Meyer Memorial Hospital and Grasslands Hospital. Does not include a small, but unknown, amount of care in private hospitals at public expense.

e/ Data for 1944.

f/ Data for fiscal year ending October 1943 for most hospitals.

as facilities permit, and also may arrange to accept the residents of counties not having their own institutions. City hospitals must accept residents who need care and, if facilities are adequate, may accept patients from outside of the city.

State and city hospitals are financed in part through payments by patients or their relatives. The State hospitals charge the county of residence of the medically indigent patient on a per diem basis.^{5/} The State or city make up the remainder of the cost for their respective hospitals. For county hospitals, however, the care of a patient who is a county resident is a county charge, regardless of his financial ability. However, if he so desires he may (and in practice may be urged to) pay part or all of the cost. The cost of care of residents of other counties is charged to the county or city responsible for providing hospital care for them.

All public tuberculosis hospitals maintain clinics for out-patient examinations. In addition, other official agencies such as county health departments frequently maintain such clinics, as indicated in Table 3. Service in out-patient clinics is generally free of charge. Mass x-ray

Table 3. Tuberculosis Clinic Service Provided Through Public Agencies in New York State

In New York State			
Public agencies	In clinics		Mass surveys
	Examinations	Individuals	
New York City ^{a/}			
City Health Department	171,793 ^{d/}	79,105 ^{d/}	12,387
Rest of State			
State tuberculosis hospitals ^{c/}	21,548	17,532	80,055 ^{e/}
City and county tuberculosis hospitals ^{b/}	62,206	52,545	
Official, other than tuberculosis hospitals ^{c/f/}	36,336	21,921	
Total	123,090	91,998	80,055
Entire State			
Total	294,883	171,103	92,442

a/ Data for 1944. Does not include 48,388 visits to tuberculosis clinics of City Department of Hospitals.

b/ Fiscal year ending October 1945.

c/ Data for 1944.

d/ In addition there were 15,000 cases referred by private physicians for consultation. Also, 48,388 visits were made to tuberculosis clinics.

e/ Including industrial surveys made by the State Department of Health.

f/ Agencies providing these clinic services are the Health Departments of Binghamton, Buffalo, Lackawanna, Mt. Vernon, New Rochelle, Rome, Rye, Schenectady, Syracuse, Utica, Yonkers and Westchester County, and Washington County and the Erie County Nursing Service.

^{5/} Public Health Law, Sections 335 and 340 states that the Commissioner of Health shall fix the charge for care in State hospitals on a per diem basis, which shall not be greater than the actual cost of treatment, and which shall not exceed the average daily per capita cost of maintenance of six county tuberculosis hospitals. Thus, the payment may not equal the full cost of care of the patient.

survey projects are carried on by some official agencies and also by private organizations. From the fragmentary reports of these activities that are available it is estimated that more than 500,000 residents of the State outside of New York City, had chest x-ray examinations as candidates for the armed forces in the period 1940-43,^{6/} and in 1944 an estimated 91,388 persons were examined by mass x-rays in that part of the State, in addition to which many thousands were x-rayed in connection with pre-employment and employment examinations in industry. In addition, a few general hospitals (Strong Memorial and the Rochester Municipal in Rochester, and possibly others) have begun the practice of routinely examining by x-ray all patients, regardless of type. Most of these mass x-ray projects were financed from private funds, but the State Health Department interpreted approximately 50,000 of these x-rays free of charge; the cost of this service to the State is included in the general budget of the department.

The per diem cost per patient was \$5.38 for State hospitals and \$3.76 for city and county institutions, exclusive of New York City, as shown in Table 4; these figures include the cost of operating clinics.^{7/}

New York City. In New York City, under authority given by the City Charter, the New York City Department of Hospitals operates three tuberculosis hospitals: Municipal Sanitarium, Seaview and Triboro Hospitals. In addition, seven public general hospitals provided provisional tuberculosis service in 1944,^{8/} i.e., they hospitalized tuberculosis patients for limited periods of time, for treatment or preceding admission to the tuberculosis hospitals. The facilities of these institutions are indicated in Table 2. In 1944, the per diem cost per patient in the three tuberculosis hospitals was \$3.94. Only one of the three tuberculosis hospitals, Triboro, maintains out-patient facilities. However, New York City's general hospitals do some tuberculosis out-patient work; in 1944, 46,388 out-patient visits for tuberculosis were made to the municipal hospitals, 2,617 of which were

6/ "Recent Trends in the Early Diagnosis of Tuberculosis" Edward X. Mikol, M.D. and Robert E. Plunkett, M.D., American Journal of Public Health, 35:1260, December 1945.

7/ The State hospitals conduct clinics throughout their districts. The county responsible for the patient is charged for bed-patients, but no charge-back is made for clinic patients because of the provisions of the Public Health Law cited in Footnote 5. Thus the State absorbs the cost of clinic care of persons in the State hospital districts.

8/ Bellevue, City, Harlem, Kings County, Kingston Avenue, Metropolitan and Riverside Hospitals. Of these, the Kings County Hospital with 200 tuberculosis beds, resumed tuberculosis service April 6, 1944 and Riverside Hospital with 284 tuberculosis beds, closed tuberculosis service April 17, 1944.

FIGURE 2. LOCATION OF CHEST CLINICS OPERATED BY NEW YORK CITY DEPARTMENT OF HEALTH, 1945

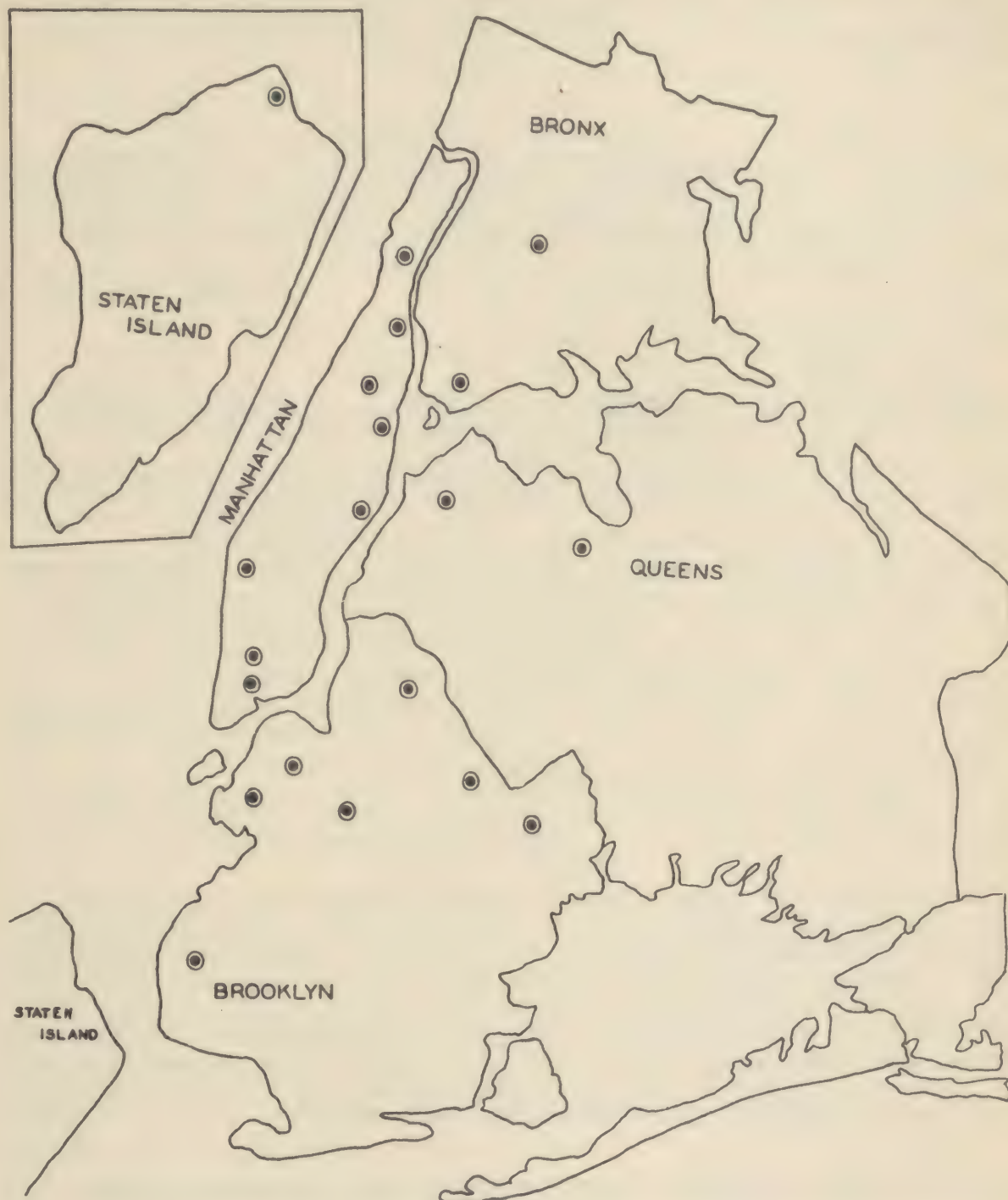


Table 4. Cost of Providing Tuberculosis Treatment in Public Clinics and Hospitals in New York State, Exclusive of Veterans Hospitals.^{a/}

Public agencies	Total cost	Source of funds		Private
		Public		
		Local	State	
New York City				
Health Department clinics ^{b/}	\$ 440,155	\$ 440,155	-	-
Hospital Department tuberculosis hospitals ^{c/}	3,554,768	3,506,823 ^{d/}	-	\$ 47,945
Total	3,994,923	3,946,978	-	47,945
Rest of State				
State hospitals ^{e/}	1,695,277	435,427	\$1,178,140	81,710
City and county hospitals ^{f/}	4,582,311 ^{g/}	4,370,540	51,269 ^{f/}	160,502 ^{f/}
Official agencies, other than hos- pitals (clinic services) ^{h/}	150,912	127,918	19,787	3,207
Total	6,428,500	4,933,885	1,249,196	245,419
Entire State				
Total	10,423,423	8,880,863 ^{d/1/}	1,249,196	293,364

a/ Estimated cost of care in veterans hospitals is \$1,577,000.

b/ For fiscal year 1943-4. Includes cost of 12,387 mass x-rays.

c/ For 1943. Includes only hospitals devoted entirely to tuberculosis and other lung conditions. Provisional tuberculosis service in city general hospitals at an estimated cost of \$1.3 million is not included here, but is included under the cost figures on public general hospitals. Does not include cost of tuberculosis clinic service in city hospitals.

d/ Does not include about \$800,000 paid by New York City Department of Public Welfare for care of cases in private tuberculosis hospitals in New York City.

e/ For fiscal year ending March 31, 1945.

f/ For fiscal year ending October 31, 1943. Includes estimated cost of tuberculosis facilities of E. J. Meyer and Grasslands Hospitals.

g/ Estimated.

h/ For calendar year 1944. Agencies holding these clinics are the Health Departments of Binghamton, Buffalo, Lackawanna, Mt. Vernon, New Rochelle, Rome, Rye, Schenectady, Syracuse, Utica, Yonkers, Westchester County, Washington County, and Erie County Nursing Service. Does not include \$7,747.50 for mass x-ray in Syracuse paid for by city. Maintenance and operation costs are at a minimum since it is generally not possible to determine such expenditures for clinic service which is given by a health department.

i/ Does not include small but unknown expenditures by local public agencies for care of cases in private tuberculosis hospitals.

were to Triboro. The cost and activities of this out-patient service is included in the material on public general hospitals.

The New York City Health Department maintains 20 tuberculosis clinics (see Figure 2) which provide the services indicated in Table 3. In 1944, mass x-rays of 12,387 persons were taken by the City Health Department, the cost of which is included in the tuberculosis clinic figures.

In evaluating the clinic services provided in New York City, the De-

partment of Health states that:

The services now conducted by the Department of Health are minimum. There is need for expansion of clinic services in several districts not now adequately covered, from the standpoint of transportation facilities to the residents of that area. There is also an indicated need for greatly increased mass survey programs in industries, and particularly among the lower income groups. This in part is being met through use of local facilities that should be augmented by mass survey equipment that can be moved from place to place.

The cause of tuberculosis would be greatly augmented in New York City if the cost of hospitalization was borne entirely by the city, and if no means test would be applied to persons in need of treatment. Furthermore, there is need for additional allowance to families in which there is a tuberculosis problem to maintain as far as possible the highest level of individual resistance to fight the disease.

It is expected that the new federal funds made available through the United States Public Health Service in the control of tuberculosis will become available in New York in the coming months. These funds will be used to expand health education, case finding, laboratory diagnostic services and statistical analyses of service data.

Concerning tuberculosis hospital care, the New York City Hospital Department estimates that:

....approximately 5,000 more beds would be needed to adequately care for all those infected with tuberculosis and who should be hospitalized, even though for short periods, as an educational and training factor where they may be taught better care and adjustment for their future economic and social life.

The surgical approach to pulmonary tuberculosis requires improved technical standards and a modified approach to the equipment of nursing care.

New buildings now contemplated as a postwar program recognize the changing scientific thought on the hospital care of tuberculosis.

Venereal Disease

The control of venereal disease differs from that of most communicable diseases in that the important factor is medical treatment of the patient rather than specific immunization, or sanitation of the environment. Thus, in this field, health departments find it necessary to conduct rather large medical care programs in addition to the conventional public health functions of aids to diagnosis, public and professional education, and reporting and statistical studies of the disease.

State exclusive of New York City. The State Public Health Law^{9/} authorizes local boards of health or district State health officers to require persons suspected of infection with venereal disease, and persons arrested for vagrancy, violation of certain provisions of the penal law, or for frequenting houses of prostitution, to submit to an examination by either the health officer or a qualified licensed physician. If such per-

^{9/} Sections 343-gg - 343-oo.

son is found to be infected, the health officer may require him to submit to treatment or quarantine or both.

It is the responsibility of the local board of health to provide adequate facilities for free diagnosis and treatment for persons in its jurisdiction, regardless of financial status of the individual.^{10/} Treatment is to be furnished without charge to any infected person who does not elect to be treated at his own expense. The State has made some funds available to assist the localities. For some years, drugs were furnished by the State only when patients could not afford to purchase them, but at present they are supplied to physicians without cost, regardless of the financial ability of the patient and regardless of whether the patient is treated at public expense or privately.

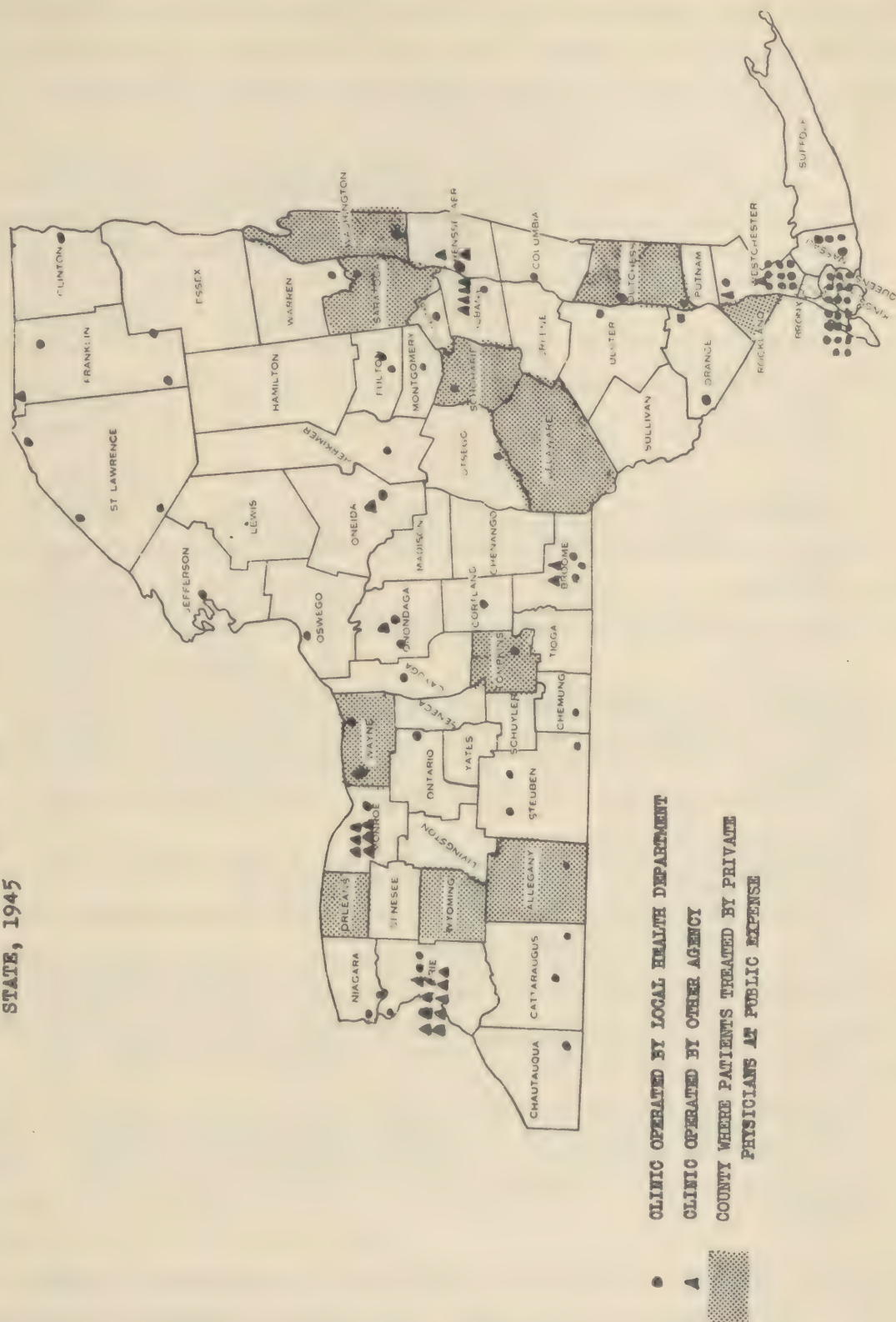
The great bulk of venereal disease treatment at public expense is provided through clinics operated by physicians paid on a salary or, occasionally, a per-session basis; and by local health officers. Clinics come under State supervision only if they are operated by a local health department or if private, if they are in receipt of public funds. Such clinics are required to accept any patient, whether or not a resident, for diagnosis and consultation, to maintain adequate facilities and to hold clinic sessions at convenient hours. In 1944, there were 66 clinics operated by local health departments, located as shown in Figure 3. Of 27 clinics operated by agencies other than local health departments, 14 had physicians paid in whole or in part by the State Health Department, chiefly from Federal grants-in-aid; the remainder operated on private funds solely. The cost per visit for local health department clinics averaged \$1.58

In rural areas, the operation of clinics is not practicable because transportation costs for regular weekly treatments are great, and a reasonable degree of privacy for the patient is not possible. For these reasons, State-aid-to-county programs have been set up in 14 counties to provide treatment on a fee basis in the offices of private physicians.^{11/} Under this arrangement, a local publicly-employed physician passes on the need for and amount of treatment.

Additional treatment facilities are made available by the State Health Department, which pays for hospitalization and penicillin therapy for per-

^{10/} The amendment providing free treatment regardless of financial status of patient was passed in 1945. Since the basis for compulsion is for the public good, it was thought that the persons infected should be cared for at public expense unless they elected otherwise. The law notwithstanding, some clinic physicians still give free service to medical indigents only.
^{11/} Eleven such counties made payment to private physicians in 1944.

FIGURE 3. VENEREAL DISEASE CLINICS, NEW YORK STATE, 1945



sons with early infectious syphilis. Also, the hospitals of the State Department of Mental Hygiene offer artificial fever treatment for syphilis of the central nervous system. This type of treatment was until recently limited to the insane, but is now being made available on a broader basis.

Table 5. Services Provided Chiefly From Public Funds For Persons With Syphilis and Other Venereal Diseases, 1944.^{a/}

Type of service	New York City	Rest of State	Entire State
Clinic service			
Local health department			
Visits	359,176	80,670	439,846
Patients	69,035	4,398	73,433
Other clinics ^{a/}			
Visits	-	45,111	45,111
Patients	-	3,144	3,144
Total			
Visits	359,176	125,781	484,957
Patients	69,035	7,542	76,577
Physician's office, fee-for-service care			
Visits	-	2,175	2,175
Patients	-	176	176
Hospitalization by Health Department			
Patients	-	229 ^{b/}	229
Days care	-	2,478 ^{b/}	2,478
Consultation with physicians ^{c/}			
Cases	12,945 ^{d/}	77	13,022
Drugs distributed to private physicians			
Patients	8,250	e/	-

a/ Includes 27 private clinics, of which only 14 received some public funds in 1944.

b/ Figures for penicillin therapy for a six month period only. Data for other types of therapy for fiscal year.

c/ Health Department physicians available for consultation with private clinics and physicians.

d/ This includes 9,491 patients referred by private physicians to Health Department clinics for consultation and 3,454 consultations by Health Department consultants with private physicians in their own offices in behalf of patients of these physicians.

e/ Records are not kept so as to show the numbers of patients treated. Drugs which were distributed for venereal disease treatment totalled \$27,356. In addition, ampules of silver nitrate solution for prevention of gonorrhea of the eye cost \$4,653.

The State Health Department comments on the service as follows:

The adequacy of the clinic service may be judged upon two bases: the availability of treatment for transmissible syphilis, and for the late complications of the disease. In my* opinion, the facilities for the treatment of cases found to be infectious are adequate for the State as a whole, though many rural communities are practically without such provision. However, the discovery rate of early syphilis does not appear to be greater than 20 per cent of the real incidence of the disease. The major deficiency in the control of transmissible

syphilis is this low discovery rate. Whether compensation for physicians for serologic tests performed would increase the discovery of such cases is a moot question. The facilities for the therapy of the late complications of the disease are assuredly inadequate, though it is impossible to gauge the degree of deficiency, for so many agencies, official and non-official, participate in the care of the late syphilitic in one way or another. I* have no doubt that more adequate compensation for physicians for the complicated and long-drawn-out care of the patient with late syphilis would lead to the prevention of an unknown number of breakdowns.

*Director of Division of Syphilis Control, New York State Health Department.

New York City. On authority granted by the City Sanitary Code,^{12/} venereal disease control in New York City is under the Bureau of Social Hygiene of the Health Department. The program of the Bureau includes the operation of 20 venereal disease clinics, (see Figure 4) the activities of which are indicated in Tables 5 and 6. The cost per visit averaged \$1.64

The Bureau supplies drugs for the treatment of venereal disease, without cost to patient or physician. In 1944, private physicians were supplied with drugs for the treatment of 8,250 patients, at a cost of \$12,000

The New York City Health Department judges their venereal disease program to be adequate, stating that:

The greatest need at the present time is for experienced and competent professional and other personnel. No changes in the laws governing the service are needed.

Cancer

The care of cancer is costly, often involving highly specialized surgical and radiation treatments, and long periods of hospital care. Although exact data are not available on the subject, it seems probable that a considerable proportion of persons suffering from cancer find it necessary at some time to turn to public agencies for assistance. This must represent a large volume of public medical care because at any given time an average of 6 per thousand persons of all ages are suffering from the disease.^{13/} The cost of diagnosis and treatment at public expense is at present covered to a large extent by the welfare and public hospital medical programs, but the importance of cancer as a chronic disabling disease often requiring prolonged hospitalization, and the high cost of equipping and operating specialized treatment centers is such that it has been developed to some degree as a separate public medical program. Because of the skilled surgery in-

^{12/} Sections 86, 88, 97, 102, and 105.

^{13/} Sixty-third Annual Report, New York State Department of Health, Volume 1, 1942.

Table 6. Cost of Providing Venereal Disease Treatment from Public Funds in 1944.

Kind of service	Cost of service	Source of funds		
		Local	State	Federal
New York City				
Clinics - physicians' salaries	\$139,122			
Other clinic personnel	394,020			
Maintenance	43,406			
Total	576,548	\$375,366	0	\$201,182
Drugs for private physicians	12,060	12,060	0	0
Total	588,608	387,426	0	201,182
Rest of State				
Local health department clinics				
Physicians' salaries	74,498			
Other clinic personnel ^{d/}	49,648			
Maintenance ^{d/}	29,134			
Total	153,280	101,692	33,220	18,368
Private clinics-physicians paid by State ^{a/}	8,100	0	7,500	600
Hospitalization for penicillin therapy ^{b/}	14,241	0	0	14,241
For other therapy ^{c/}	1,789	0	0	1,789
Drugs for private physicians	32,009	0	32,009	0
Physicians treating patients on fee-for-service basis	9,954	4,977	4,977	0
Total	219,373	106,669	77,706	34,998
Entire State				
Local health department clinics				
Physicians' salaries	213,620			
Other clinic personnel ^{d/}	443,668			
Maintenance ^{d/}	72,540			
Total	729,828	477,058	33,220	219,550
Private clinics-physicians paid by State ^{a/}	8,100	0	7,500	600
Hospitalization for intensive treatment ^{b/c/}	16,030	0	0	16,030
Drugs for private physicians	44,069	12,060	32,009	0
Physicians treating patients on fee-for-service basis	9,954	4,977	4,977	0
Total	807,981	494,095	77,706	236,180

^{a/} Includes 14 of the 27 private clinics listed in Table 1. Only part of the cost of operation of these 14 clinics is publicly financed.

^{b/} For 6 month period November, 1944 - April 1945 inclusive.

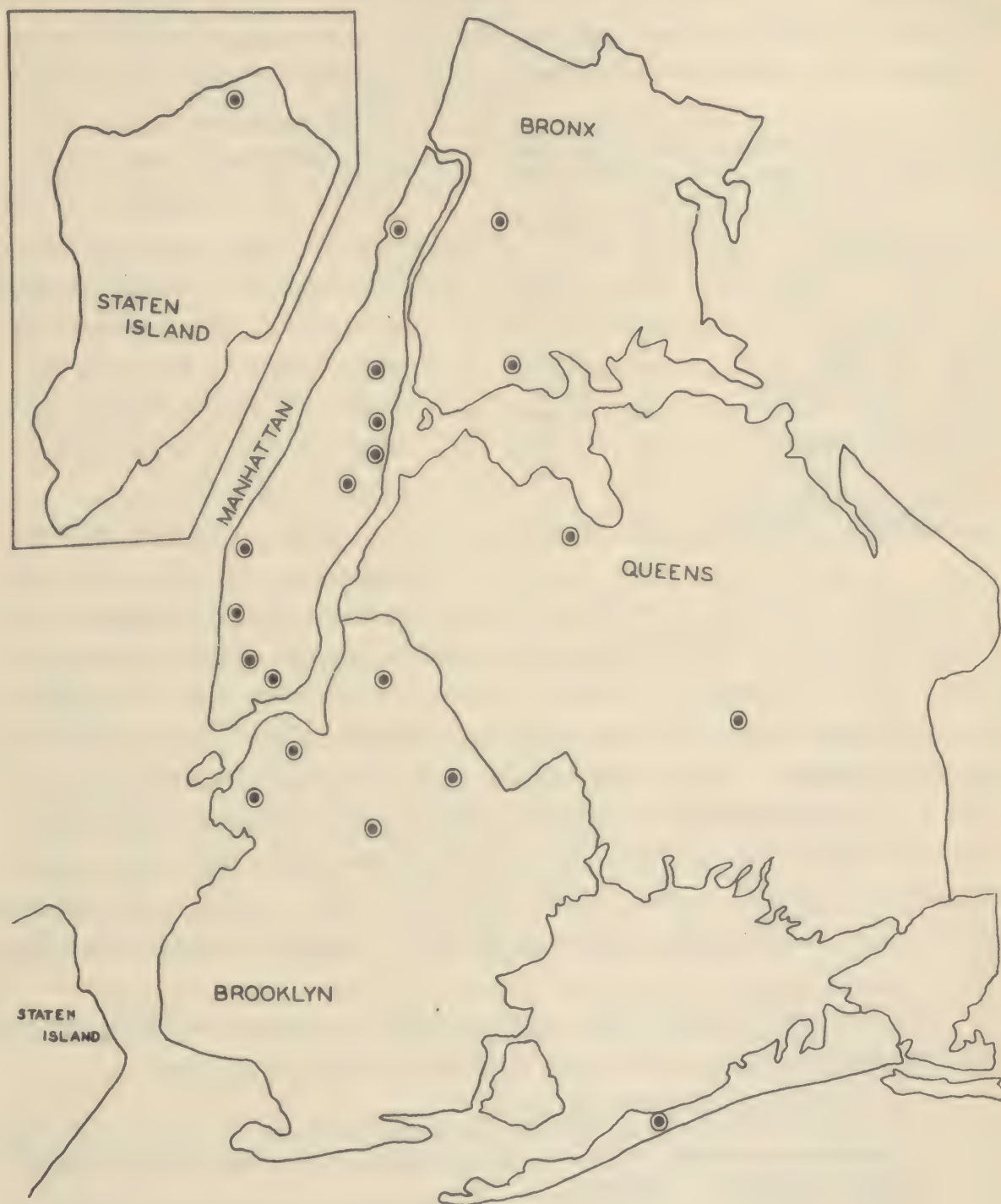
^{c/} For fiscal year 1944-5.

^{d/} Includes cost of public health nursing by the Syphilis Control Division of the City of Buffalo. Such nursing activities provided 7,472 visits to patients in 1944, at a cost of \$25,428, of which \$8,096 was from Federal and \$17,332 from State funds.

volved and the specialized personnel and facilities needed for radiation treatment, adequate cancer treatment facilities are found in only a few localities.

In establishing the State Institute for the Study of Malignant Diseases at Buffalo in 1893, New York State became the first governmental unit in the world to allot public funds for cancer research. The Insti-

FIGURE 4. LOCATION OF VENEREAL DISEASE CLINICS OF THE NEW YORK CITY HEALTH DEPARTMENT, 1945



tute has been continued as an institution in the State Department of Health ^{14/}

The State Institute for the Study of Malignant Diseases accepts cancer cases free of charge for study, experimental or other treatment, either as clinic or bed patients. Any resident of the State who is referred by a physician is eligible for admission. During 1944-45, these activities,

Table 7. Services to Patients, State Institute for the Study of Malignant Diseases, 1944-45.

Type of service	Number
OUT-PATIENTS	
Visits to clinic	37,869
No. of patients	9,089
IN-PATIENTS	
No. of beds	107
No. of patients	1,608
Days care	30,887
Major surgery	358
Minor surgery	773
RADIATION AND X-RAY TREATMENTS (FIELDS)	45,828

including research, cost the State \$471,583. The distribution of the cost among the various services is not available. Services were rendered as shown in Table 7. The Institute is used chiefly by patients and physicians in the western part of the State, because of its location in Buffalo.

State exclusive of New York City. In addition to the

work of the Institute in cancer research, the State Health Department exercises the general public health functions of investigating causes, mortality rates, methods of treatment, prevention and cure, and of cooperating in the development of local public and private facilities for diagnosis and treatment. Also, some medical care is furnished directly to patients at health department expense. Aside from providing consultation service to non-official tumor clinics, the State Health Department in the year 1944-45 granted a total of \$2,013 to 12 clinics to help pay clinicians and clerical workers, and a total of \$970 to 4 clinics for clinical assistants.

The State Health Department has pointed out a number of needs and has made recommendations for action in regard to cancer as follows:

The following needs exist:

1. For better quality of medical services in tumor clinics, i.e., more physicians trained in the various specialties needed in diagnosis and treatment of cancer.
2. For financial provision for patients who are medically needy, not otherwise eligible for public assistance.
3. For making radium and/or radon available to more clinics.
4. For institutional care of the chronically ill cancer patient.

Recommendations for action:

1. State aid for postgraduate training of physicians in cancer specialties, in the form of fellowships for periods ranging from 3

^{14/} Under authorization of the Public Health Law, Sections 344-348.

- months to 1 year. Grants to be made by the State Department of Health, Division of Cancer Control.
2. Building of "chronic cancer pavilions" attached to teaching hospitals, for care of advanced cancer, with research into improvement of such care.
 3. Radium and radon now available at the State institute for the study of Malignant Disease, plus additional amounts to be purchased, to be made available to tumor clinics and qualified clinicians for use in care of cancer patients.
 4. Institutional provision for the chronically ill cancer patient, in the form of chronic disease hospitals and custodial "wings" attached to or in close association with, general hospitals throughout the State.

New York City. The treatment of cancer at public expense is provided, under authority of the City Charter, by the City Department of Hospitals through its special hospitals, the New York Cancer Institute and the Brooklyn Cancer Hospital (a division of the Kings County Hospital), and through the general city hospitals and their out-patient departments.^{15/} In 1944, the 277 beds in the special cancer hospitals were occupied at 92 per cent of capacity in providing 92,688 days care to 1,771 patients.

Costs for patients hospitalized in the Brooklyn Cancer Hospital are not available separately from those of the Kings County Hospital. The New York Cancer Institute was operated in 1944 at a daily per capita cost of \$4.59, or a total of \$314,399 which, except for \$3,500 paid by patients, was paid by the City.

Post-war plans for public cancer facilities include construction of the 400 bed James Ewing Memorial for terminal cancer patients, in collaboration with and adjoining the Manhattan General Memorial Hospital. The Nightingale Hospital at Columbia Medical Center will provide a 300 bed institution for cancer and allied diseases, and the Brooklyn Cancer Hospital and the cancer facilities in the Queens General Hospital will be enlarged.

Federal. The Federal government, through the United States Public Health Service has loaned radium to certain treatment centers in the State. Originally intended for the indigent, its use is now permitted for all persons. The recipient institution agrees to make no charge for the Federally owned radium, although a charge may be made to persons able to pay, representing the value of personnel and other costs. The use of Federal radium results in a reduction of about 20 per cent in the cost of treatment, but the great value of this program lies in the fact that it makes radium available in communities which would be unable to afford the great initial cost.

^{15/} See Chapter VII for out-patient service figures.

Mental Hospital Care

Very little hospital care for the mentally ill is provided from private funds or in private hospitals. Aside from criminally insane patients, 106,383 persons were cared for in mental hospitals in the State in the period July 1, 1942 - March 31, 1943. Of these, 4,073 or 3.8 per cent were cared for in Federal veterans and U.S. marine hospitals, 4,510 or 4.2 per cent in licensed private institutions, and the remaining 97,800 or 92 per cent in State civil mental institutions.^{16/}

New York State has always been among the more progressive in the matter of public provision for the humane care of the mentally afflicted. From the opening of the first insane asylum at Utica over one hundred years ago, New York has shown an increasing desire to provide adequate facilities for the care of the mentally ill. The passage of the State Care Act by the Legislature in 1890 marked the first recognition by a State government that care of the medically indigent was a State rather than a local responsibility. Prior to this, institutions were under State control, but the cost was a charge against the county responsible for the individual patient.

At present the law delegates to the State Department of Mental Hygiene the responsibility for care and treatment of the insane, mental defectives and epileptics throughout the State in State institutions especially established for the purpose; the licensing and inspection of private mental institutions; the establishment and maintenance of colony, clinic, and family care facilities; the operation in New York City of a psychopathic hospital for teaching and research and a psychopathic hospital in Syracuse for teaching and for observation and temporary treatment of mental patients; and the collection of moneys from relatives of patients and from patients' estates to reimburse the State for the maintenance of the patient.

Institutional care. The Department of Mental Hygiene operates 20 State hospitals, five State schools and one colony for epileptics, as indicated in Table 8 and Figure 3.^{17/} The hospitals are intended for the insane, and the schools for mental defectives who are of sufficient intelligence to profit by instruction to a point where they can manage for themselves and for those of such low grades of mentality that they must

^{16/} Fifty-fifth Annual Report of the Department of Mental Hygiene, 1944.

^{17/} A new hospital, Edgewood, was turned over to the Army for use as a military hospital (Mason General Hospital). The Willowbrook State School, newly constructed to relieve the overcrowding of the existing schools, was turned over to the U. S. Army in 1942 for use as a military hospital (Halloran General Hospital).

Table 8. Hospitals, Schools and Epileptic Colony Operated by the New York State Department of Mental Hygiene. Number of Beds, Average Census and Number of Admissions in 1944.a/

Institution	Beds	Average census	Admissions	Per cent occupancy	Average stay (days)
Hospitals					
Binghamton	2,974	2,666	695	90	1,400
Brooklyn	3,400	3,323	3,370	98	360
Buffalo	2,589	2,498	746	96	1,222
Central Islip	8,067	7,141	1,307	89	1,994
Creedmoor (Queens Village)	4,860	4,425	1,009	91	1,601
Gowanda (Helmuth)	2,858	1,973	720	69	1,000
Harlem Valley (Wingdale)	4,627	4,815	574	104	3,062
Hudson River (Poughkeepsie)	4,916	4,808	768	98	2,285
Kings Park	6,586	6,171	1,474	94	1,528
Manhattan	3,830	3,516	2,733	92	470
Marcy	2,776	2,500	533	90	1,712
Middletown	3,464	3,393	384	98	3,225
Pilgrim (Brentwood)	9,529	9,522	1,840	100	1,889
Rochester	3,324	3,090	657	93	1,717
Rockland (Orangeburg)	6,408	5,887	1,375	92	1,563
St. Lawrence (Ogdensburg)	2,275	2,268	467	100	1,773
Utica	1,779	1,754	530	99	1,208
Willard	3,104	2,928	406	94	2,632
Psychiatric Institute, New York City	150	122	313	81	142
Syracuse Psychiatric	60	43	558	72	28
Total	77,576	72,843	20,459	94	1,300
Schools					
Letchworth Valley (Thiells)	3,690	4,085	462	111	3,227
Newark	2,616	2,343	230	90	3,718
Rome	4,000	3,952	234	99	6,164
Syracuse	1,166	962	157	83	2,236
Wassaic	4,394	4,408	309	100	5,207
Total	15,866	15,750	1,392	99	4,130
Epileptic Colony					
Craig Colony (Sonyea)	2,172	2,218	2,015	102	402

a/ Data from "Hospital Service in the United States," Journal of American Medical Association, 127:771, March 31, 1945.

be cared for as long as they live. The schools operate small supervised units, or colonies, detached from but under the control and direction of a parent institution, to serve as a means of transition from institutional life to life in the community and as a place for modified custodial care of patients able to adjust to a semi-independent life, but not capable of living on their own in a community. Craig Colony is for the care and treatment of epileptics who are mentally incompetent but not insane. A number of patients whose condition warrants such provision are "boarded out" in family homes, the State paying at a weekly rate for their upkeep. As of

March 31, 1945 the State hospitals supervised 1,017 patients in family care, the State schools supervised 621 such patients, and Craig Colony had no such patients. The cost of family care during the year was \$650,437.

Out-patient care and preventive work. Limited-out patient and preventive work is provided through child guidance clinics and State hospital clinics, located as shown in Figure 5. The child guidance clinics are directed by psychiatrists on the staff of the Department of Mental Hygiene and by members of the medical staffs of several of the State hospitals. In the year ended March 31, 1945 there were 3,055 visits to 510 clinics held in 68 communities. The cost was \$46,218. Each State hospital conducts out-patient mental hygiene clinics, many of them holding clinics at several centers throughout their areas. They are primarily for patients paroled from the State hospitals, but nearly all are open also to provide advice to the public, both children and adults.

Table 9. Child Guidance and Mental Hygiene Clinics Conducted by the New York State Department of Mental Hygiene

Clinic visits	Child guidance clinics ^{a/}	Mental hygiene clinics ^{b/}				
		Ex-hospital		Community cases		
		Paroled patients	Discharged patients	Adult	Child	Total
First in year	1,904	5,702	233	503	573	7,011
Subsequent	1,151	23,441	693	647	409	25,190
Total	3,055	29,143	926	1,150	982	32,201

^{a/} Data for year ending March 31, 1945.

^{b/} Data for year ending March 31, 1944.

During that year, 32,201 visits, of which only 2,132 were by other than ex-hospital patients, were made to the mental hygiene clinics. The cost is included in the general cost of operation of the hospitals shown in Table 10.

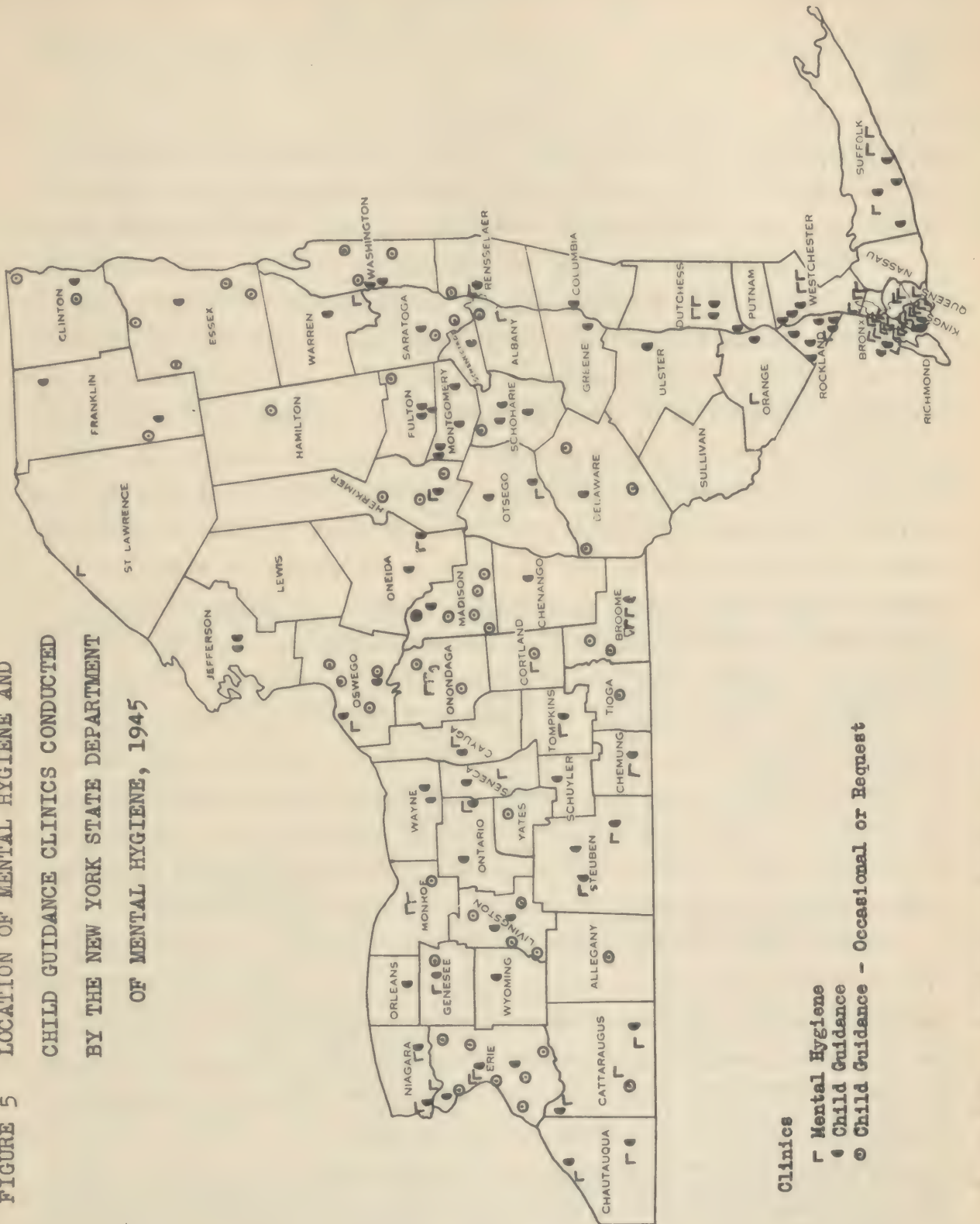
Table 10. Cost of Operation and Source of Funds of Hospitals, Schools and Colonies Operated by the New York State Department of Mental Hygiene for the Year Ended March 31, 1945.

Item	Cost	Source of funds	
		Patients	State
Hospitals	\$36,201,693	\$ 4,891,079	\$31,310,614
Schools & Craig Colony	7,357,761	463,038	6,894,723
Administration & other expenses ^{a/}	1,277,072	-	1,277,072
Total	44,836,526	5,354,117	39,482,409

^{a/} Includes cost of child guidance clinics, State hospital retirement fund and general administration, prevention work, transfer and removal of patients.

The State hospitals, colonies and schools are State-supported and accept poor and indigent cases at no cost, or at partial cost, depending

FIGURE 5 LOCATION OF MENTAL HYGIENE AND
CHILD GUIDANCE CLINICS CONDUCTED
BY THE NEW YORK STATE DEPARTMENT
OF MENTAL HYGIENE, 1945



on the financial resources of the patient. Persons who can afford to pay for their own care are admitted if there are facilities in excess of those needed for provision for the poor and indigent.^{18/} The law has always contemplated that the patient or legally liable relatives (husband, wife, father, mother and children) should be liable for the cost of care, it being argued that if a charge were not made, the relatives responsible for the support of the patient would escape an obligation that would be imposed upon them if the patient remained at home. Until recently, about 11 per cent of patients had some private payment made for their care, the amount averaging about \$325 per patient per year, and the total income to the State being \$2.5 million in the year 1940-41, and \$2.8 million in the year 1941-42. On recommendation of the Commission to Investigate the Management and Affairs of the Department of Mental Hygiene,^{19/} more strenuous efforts have been made to collect from responsible relatives; this and improved economic conditions have raised the amount collected to \$5.4 million in the year ended March 31, 1945. Although this may be good business practice, the question may be raised as to whether it encourages prompt diagnosis and treatment of mental disease. It might be argued that mental disease is largely a public responsibility, that the mentally ill patient abroad in the community is a public menace, that the patient is compelled by legal process to submit to hospital confinement, and that treatment should be provided without reference to ability to pay (as is increasingly the case in the care of tuberculosis and venereal disease). The practice of requiring payment for mental hospital care, coupled with the extremely small amount of out-patient care given, suggests that insufficient emphasis is placed on preventive and other early treatment.

General hospitals in several communities maintain divisions for the study and classification of mental patients. For example, New York City's Bellevue Hospital and Kings County Hospital operate psychiatric services for short-term observation of mental patients. The cost to the public of operating these units, which are quite different in character from the State mental hospitals, is shown in Chapter VII.

^{18/} The Mental Hygiene Law, Section 2, defines a "poor person" as "a person who is unable to maintain himself and having no one legally liable and able to maintain him." An "indigent person" is a person "who has not sufficient property to support himself...and to support the members of his family lawfully dependent upon him for support."

^{19/} Care of the Mentally Ill in New York State, Report of the Commission to Investigate the Management and Affairs of the Department of Mental Hygiene, 1944.

CHAPTER VII

PUBLIC MEDICAL CARE, CONTINUED

(VETERANS, PUBLIC GENERAL HOSPITALS AND PUBLIC WELFARE MEDICAL PROGRAMS)

Veterans

Hospital and clinic care of veterans for service connected disabilities, and hospital care for non-service connected disabilities in cases where the veteran finds it a hardship to pay^{1/}, are provided at Federal expense by the Veterans Administration, chiefly through its system of hospitals. Although hospitalization is available for both service connected and non-service connected disabilities, out patient treatment is provided solely for the former. In 1942, for the entire country, 94.6 per cent of the veterans hospitalized were treated for non service-connected disabilities^{2/}.

The facilities of the veterans hospitals in New York State are shown in Table 1. These hospitals admit anyone eligible for care, regardless

Table 1. Veterans Administration Hospitals in New York State, 1944^{a/}

Type ^{b/}	No. of hospitals	Beds	Average census	Per cent occupancy	No. of admissions	Per diem cost per patient ^{c/}
General	4	2,871	2,016	70.2	14,441	\$6.52
Mental	2	4,057	4,027	99.3	2,321	3.07
Tuberculosis	2	1,214	961	79.2	1,431	6.22
Total	8	8,142	7,004	86.0	18,193	

a/ "Hospital Service in the United States", Journal of the American Medical Association, 127:771, March 31, 1945.

b/ The general hospitals are located at Batavia, Bath, New York City and Saratoga Springs; the tuberculosis hospitals are located at Castle Point and Sunmount; and the mental hospitals are at Canandaigua and Northport.

c/ Obtained from Veterans Administration. Cost for October, 1945.

1/ Although the law stipulates that non service connected disabilities are to be treated only in the medically indigent cases, the Veterans Administration has announced virtual elimination of this requirement. There is pressure from groups such as the American Legion to completely eliminate the financial question in providing veterans care (New York Times, November 25, 1945). The American Medical Association, however, passed a resolution at its 1945 meeting expressing opposition to the extension of veterans' medical benefits to cover non-service-connected disabilities (Journal of the American Medical Association, 129:1202, December 22, 1945).

2/ Hearings Before a Subcommittee of the Committee on Education and Labor, U. S. Senate, Part 6, September 18, 19 and 20, 1944.

of his place of residence. They also conduct out patient clinics to which, in the year ended June 30, 1945, there were 78,008 visits. The cost of operation of the institutions for that period, including out-patient service, totaled \$8,299,000; the per diem costs are shown in Table 1.

The average length of stay of 51 days in veterans hospitals is significantly longer than that in private or other public hospitals, which is about 12 to 19 days. This longer period of hospitalization may be caused to some extent by the chronic nature of service-connected disabilities (which, however, account for only a very small proportion of cases), but more by the fact that veterans hospitals are generally located at a distance from centers of population, which tends to discourage the individual from making the trip to a hospital unless the illness promises to be a lengthy and costly one, and to prolong the hospital stay until after care that would ordinarily be given in a physician's office or in a clinic is completed. It has been suggested also that there is unnecessary hospitalization for non-service-connected disabilities since out-patient care is not provided for these cases.

The Veterans Administration spent \$260,000 in the year ended June 30, 1945 for hospitalization of veterans in New York State in other than its own hospitals. This care was furnished for the most part for general medical and surgical conditions in hospitals under the jurisdiction of the Navy Department and the U. S. Public Health Service, and to a lesser extent in private and in State institutions.

The demand for medical service under the Veterans Administration is expected to increase greatly in the next several years. It is planned to expand veterans hospital facilities in the State to 16,640 beds by 1950, of which 6,550 will be for general cases, 8,440 for neuropsychiatric cases and 1,650 for tuberculosis cases. In view of the anticipated increase in demand for medical and hospital care, and the probable liberalization of provisions for veterans' non-service-connected disabilities, several experiments are being made in an attempt to make better medical care more readily available to the veteran in his own community through community resources. At a national meeting of the Blue Cross Hospital Service Plans in October 1945, Federal Veterans Administrator Gen. Omar Bradley asked the Blue Cross plans to consider

enrolling veterans and their families, presumably with the government paying premiums for the veterans.

A complete medical out patient clinic for the care of disabled veterans, the first clinic of its kind, has been set up by the Veterans Administration in New York City to simplify the provision of out patient service for service-connected disabilities for residents of the New York City area.

To ease the demand on veterans facilities, and to make care more readily available, experiments are under way in Monmouth County, New Jersey and in the State of Michigan, to provide medical care for veterans in their own communities, through their own physicians. Michigan Medical Service, Inc., with the cooperation of the State medical society is selling medical service to the Veterans Administration in instances where care cannot be provided through Veterans Administration facilities; the physicians treat veterans for service connected disabilities and are paid by the Veterans Administration on the basis of a standard fee schedule.

These new developments would appear to indicate the willingness of the Veterans Administration to experiment in the provision of limited services, at least, through voluntary non profit organizations. It is also possible that Federal or State medical insurance plans may be used in the future.

Public General Hospitals

Public hospital care is one of the earliest forms of providing medical care to the poor. As a general method, it provides a more suitable environment for the care of the sick than does a low income home, and a part of the cost to the community for such hospital care tends to be cancelled by the fact that it is not necessary to provide food, shelter and clothing for the indigent person in his own home, this being particularly true in the case of care required over a long period of time. Some public hospitals continue to reflect their early identity or association with almshouses, but most of them more closely resemble private or voluntary hospitals; in fact, some public hospitals owe their title only to the fact that they were erected at public expense and are operated by the municipality. Their revenues are derived from private patients, private philanthropy, and welfare departments in the same fashion as the revenues of private, non profit hospitals. Another factor tending to favor the development of public hospitals is that professional care therein is often given free of

charge by private physicians, or by salaried physicians at relatively low cost.

The term "general hospital" as employed in this study includes special hospitals for contagious disease, orthopedic care, etc., as well as general hospitals, but tuberculosis, mental and other chronic disease hospitals have been either wholly excluded, or an appropriate subclassification has been made when such services could not be wholly separated from general hospital services. The public general hospitals of New York State account for approximately 27 per cent of the bed capacity, 21 per cent of the admissions, and 28 per cent of the patients under care in all general hospitals, as shown in Table 2. The care of patients therein at public expense totals over \$28,000,000 annually,^{3/} and patients pay from their own resources more than \$5,000,000 annually.

State exclusive of New York City. Authority for the establishment of municipal general hospitals by cities and counties, exclusive of New York City, was granted by the Legislature in 1910.^{4/} At present there are 27 general hospitals and 4 contagious disease hospitals operated by

Table 2. Public and Private General^{a/} Hospitals in New York State, Excluding Tuberculosis and Mental Hospitals, Facilities and Utilization in 1944^{b/}

Type	No. of hospitals	No. of beds	No. of admissions	Average census	Per cent occupancy	Average stay (days)
New York City						
Public ^{c/}	16	13,267	205,204	10,612	80	18.9
Private	147	26,760	544,404	18,950	71	12.7
Total	163	40,027	749,608	29,562	74	14.4
Rest of State						
Public ^{d/}	31	4,539	77,219	3,255	72	15.2
Private	259	21,785	495,633	16,219	74	11.9
Total	290	26,324	572,852	19,474	74	12.4
Entire State						
Public	47	17,806	282,423	13,867	78	17.8
Private	406	48,545	1,040,037	35,169	72	12.3
Total	453	66,351	1,322,460	49,036	74	13.5

^{a/} Includes general hospitals as such, and special hospitals for isolation, cancer, etc., but excludes tuberculosis and mental hospitals.

^{b/} From "Hospital Service in the United States", Journal of the American Medical Association, 127:771, March 31, 1945. For hospitals not included in the Journal, data were obtained from hospitals directly.

^{c/} The figures for New York City public hospitals differ slightly from those in Table 3, which were obtained from the City Health Department.

^{d/} Excludes tuberculosis facilities in E. J. Meyer and Grasslands Hospitals.

^{3/} In addition, about \$4,000,000 was paid from public funds for the care of patients in general hospitals other than public.

^{4/} General Municipal Law, Section 126.

local governmental bodies in the State, exclusive of New York City (see Figure 1) ^{5/} Several of the general hospitals include facilities for tuberculosis and contagious disease treatment. Generally, a considerable proportion of the facilities of these institutions are used for the care of persons for whom public welfare authorities are responsible. Local welfare agencies are charged by the hospitals on a per diem basis for public charges being hospitalized, patients who can pay part or all of their own bill are billed on the basis of ability to pay, and some patients are cared for at general public expense.

The 4,539 beds of these hospitals were utilized at 71 per cent of capacity in 1944. Data on the number of visits to their out patient facilities were not obtained. The cost of operation, including out patient services, was \$7,212,585 in 1944. As indicated in Table 3, this cost was met through patients' payments to the extent of \$3,420,000, through public payments of \$3,648,000, and through private funds from other sources of \$171,000, giving a total income of \$7,238,000. It was not possible to determine from the available data the exact sources of the public funds.

New York City. The system of public hospitals in New York City ^{6/} includes general hospital facilities, and special facilities for chronic

^{5/} The general hospitals are: Memorial Hospital of Wm F. and Gertrude Jones (Wellsville), Binghamton City Hospital, Ideal Hospital of Endicott, City Hospital of Salamanca, Jamestown General Hospital, The Hospital of Sidney, E. J. Meyer Memorial Hospital of Buffalo, Lake Placid General Hospital, Memorial Hospital of Greene County at Catskill, Noble Foundation Hospital at Alexandria Bay, Lewis County General Hospital at Lowville, ~~Canastota~~ Memorial Hospital, Oneida City Hospital, Rochester Municipal Hospital, Monroe County Infirmary at Rochester, Meadowbrook Hospital at Hempstead, Lockport City Hospital, DeGraff Memorial Hospital at North Tonawanda, Oneida County Hospital at Rome, Utica General Hospital, Rome Hospital and Murphy Memorial Hospital. Syracuse City Hospital, Albert Lindsay Lee Memorial Hospital at Fulton, Massena Memorial Hospital, Seneca Falls Hospital, Grasslands Hospital at Valhalla, and Wyoming County Community Hospital at Warsaw.

The communicable disease hospitals are: Consolidated Contagious Hospital at Watertown, Niagara Falls Municipal Hospital, Schenectady Isolation Hospital and Yonkers City Hospital for Communicable Diseases.

^{6/} Authorized by the City Charter, Sections 560, 585, 586 and 587. They are: General - Bellevue, City, Coney Island, Cumberland, Fordham, Gouverneur, Greenpoint, Harlem, Kings County, Lincoln, Morrisania, and Queens General; Communicable disease - Kingston Avenue, Queensboro, Richmond Boro and Willard Parker; Tuberculosis - Municipal Sanatorium, Seaview, Triboro and Riverside (closed April 17, 1944); Other - New York Cancer Institute, and Goldwater Memorial (chronic).

FIGURE 1. PUBLIC GENERAL HOSPITALS, NEW YORK STATE, 1945

EXCLUSIVE OF NEW YORK CITY



illness, tuberculosis, cancer and psychiatric cases (see Figure 2). Although the hospitals are maintained primarily for indigent persons, other persons who can pay part or all of the cost of treatment are admitted and charged on the basis of their ability to pay. Except for tuberculosis (and for homes for the aged and infirm^{7/}) all of these hospital facilities have been classed as general inasmuch as it is chiefly the high degree of specialization afforded by a system of more than 13,000 beds which permits the classifications mentioned above and shown in Table 4. Nearly all general hospitals of average size have a few beds which are occupied by cancer, chronic disease and short term psychiatric cases. For the New York City public hospital system as an entity, the types of service offered, the volume of service, costs and sources of funds have been summarized in Table 4.

Table 3. Public General and Isolation Hospitals in New York State, Exclusive of New York City. Facilities, Cost of Operation and Source of Income, 1944 ^{a/}

	General	Isolation	Total
Facilities			
Beds	4,539	230	4,769
Average census	3,255	57	3,312
Bassinets	476 ^{b/}	0	476 ^{b/}
Operating expense			
Services to patients	\$6,970,707	\$183,108	\$7,153,815
Other costs	58,770		58,770
Total	7,029,477	183,108	7,212,585
Income by type of service and source			
For in patients			
Patient	\$3,321,463	\$ 59,523	\$3,380,986
Public funds	3,392,840	123,539	3,516,379
For out-patients			
Patient	38,698	46	38,744
Public funds	131,390		131,390
Other private	170,559		170,559
Total	7,054,950	183,108	7,238,058

^{a/} From "Hospital Service in the United States", Journal of the American Medical Association, 127:771, March 31, 1945. For institutions not included in the Journal, data were obtained from the hospitals directly. Financial data are those reported on Form H-2 to the State Department of Social Welfare. Excludes tuberculosis units of E. J. Meyer and Grasslands Hospitals.

^{b/} Data incomplete.

^{7/} These provided 1,098,148 days care in 1944.

FIGURE 2. LOCATION OF PUBLIC GENERAL HOSPITALS, NEW YORK CITY, 1945

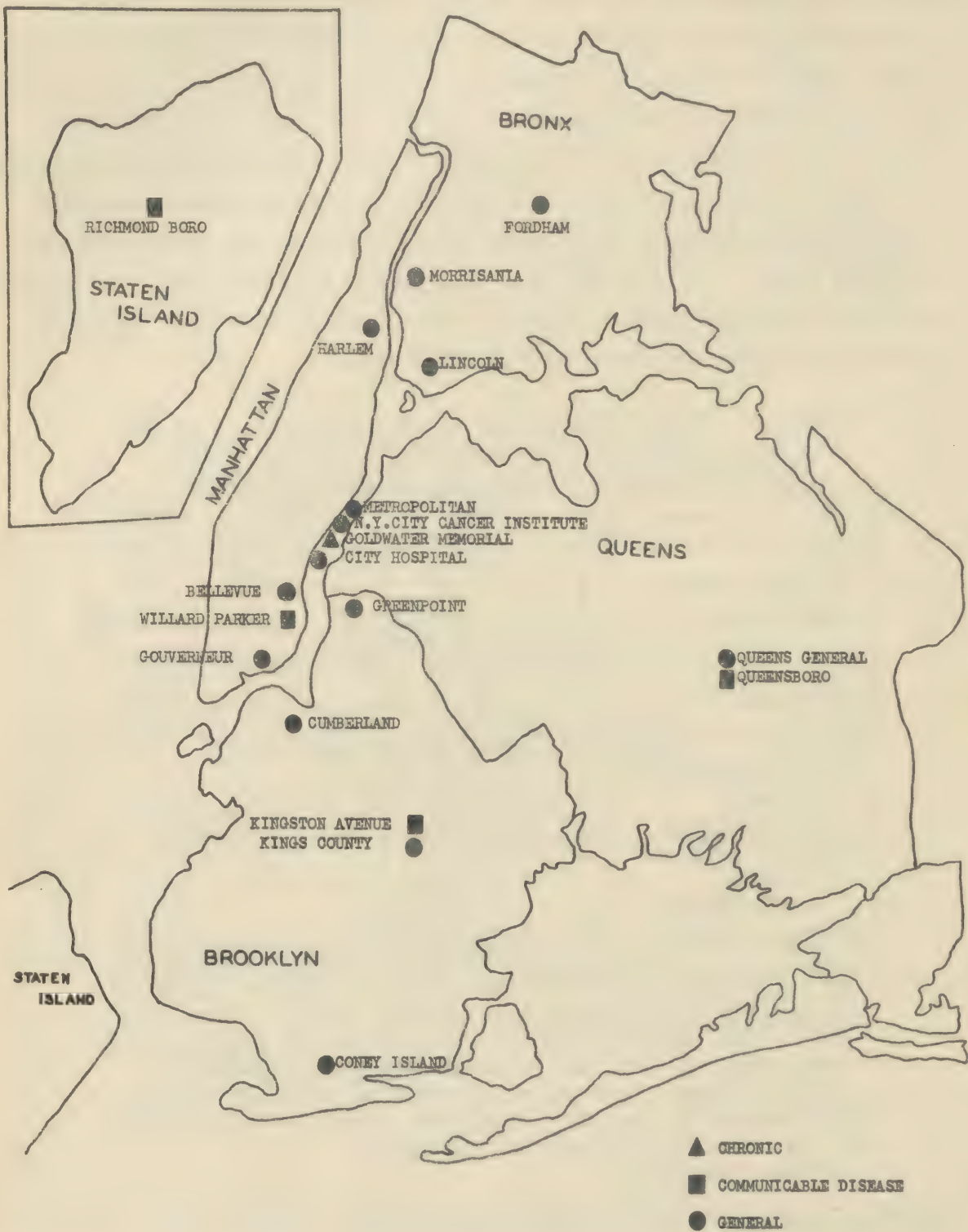


Table 4. Facilities, Services, Costs and Sources of Funds, Public General Hospitals,
New York City Department of Hospitals, 1944

Type of service	Service			Costs		Source of funds	
	Beds	Patients received	Length of stay	Total (thousands)	Per diem	Patients (thousands)	Public (thousands)
General hospital care							
Cancer b/	277	1,771	52.3	\$ 314.4	\$4.59	\$ 3.5	\$ 310.9
Chronic	1,660	3,207	108.4	1,947.8	3.28	21.4	1,926.4
Psychiatric c/	705	29,507	8.5	-	-	-	-
Isolation	1,033	9,929	19.0	1,607.6	8.44	26.0	1,581.6
Other d/	9,632	176,064	14.0	22,553.9	7.03	1,188.5	21,365.4
Total	13,307	220,478	-	26,423.7	-	1,239.4	25,184.3
Tuberculosis							
Total e/	4,225	11,407	106.8	3,554.8	3.94	47.9	3,507.1
All types of care							
Total	17,532	231,885	-	29,978.5	-	1,287.3	28,691.4

a/ All moneys collected are paid to the City Treasurer.

b/ Beds and service figures for New York Cancer Hospital, and Brooklyn Cancer Hospital (a division of Kings County Hospital); financial data for former only.

c/ Financial data included in "Other general" since these beds are located in general hospitals.

d/ Financial data include cases in psychiatric divisions of Bellevue and Kings County Hospitals (249,868 days care), Brooklyn Cancer Division of Kings County Hospital (24,236 days care), and cases in tuberculosis divisions of Bellevue, City, Harlem, Kings County, Kingston Avenue, Metropolitan, and Riverside Hospitals (80,000 days care).

e/ Data for 3 tuberculosis hospitals totalling 2,751 beds, and for 1,474 provisional beds for tuberculosis which are situated in 7 general hospitals. 484 of the provisional beds were devoted to tuberculosis for only a part of the year. The length of stay in regular tuberculosis hospitals averaged 160 days; in the provisional tuberculosis beds, 55.4 days only. Financial data for the 3 regular tuberculosis hospitals only.

The 9,632 purely general hospital beds provided nearly 2.5 million days care for 176,000 patients who stayed an average of 14.0 days. The cost per day varied from \$5.81 to \$9.62 with an average of \$7.03. The total cost was \$22.6 million. In commenting on these facilities, the Department of Hospitals stated:

Many of our present institutions are old and lacking in modern arrangements and facilities. The post-war program plans to replace these older structures completely: Bellevue, City, Fordham, Gouverneur, Harlem and Metropolitan. Reconstruction and renovation is planned on such institutions as Cumberland, Greenpoint, Kings County (in part), Lincoln, Morrisania, and Queens General.

At present, there are two isolation hospitals (Kingston Avenue and Willard Parker) and two isolation wards of general hospitals (Queensboro and Richmond Boro). In 1944, the isolation facilities totalled 1,033 beds and accommodated 9,929 patients for a total of 190,578 days. The cost per day ranged from \$6.61 at Kingston Avenue to \$11.02 at Willard Parker, with an average of \$8.44 per day. The total cost was \$1.6 million.

The postwar plans of New York City for its system of contagious disease hospitals are:

The establishment of a research division in collaboration with Columbia University. An institution of 300 beds to be used as a treatment and teaching center for all contagious and communicable diseases. Each of the new large general hospitals, five of which are planned, will be provided with a contagious disease division of approximately 75 beds. This arrangement will decentralize the contagious hospitals at Kingston Avenue and Willard Parker Hospitals....

In conjunction with the 300 bed Communicable Disease Hospital, there is to be a 100 bed section of these 300 beds devoted to the care and treatment and teaching of 'Tropical Diseases'. Also 50 beds of the 300 beds are to be set aside for research and teaching under the direction and supervision of the Health Department Research Laboratories, which will be located in an adjoining building.

Bellevue and Kings County Hospitals have special psychiatric divisions with a total bed capacity of 705. These facilities are primarily for observation and classification of mental patients, custodial care being given in the State mental hospitals. In 1944, the psychiatric facilities provided 249,668 days care for 29,507 patients who stayed an average of 8.5 days. The cost of this service is included in the over-all cost of Bellevue and Kings County Hospitals. It is proposed in the future to

....establish in each borough of Queens, Bronx and Richmond a district psychopathic division, with mental hygiene clinics adequately constructed and organized to care for these sections of

the city, more on a community basis.

The Goldwater Memorial Hospital has been established as a part of the municipal hospital system to provide scientific care, including neurological and traumatic surgery, for patients suffering from chronic maladies. In 1944, it accommodated 3,207 patients for a total of 594,493 days' care in its 1,660 beds. The cost per day was \$3.28. The total cost was \$1,947,800. Postwar planning contemplates

...the construction of a 1,500 bed hospital for chronic diseases on the present site of the Metropolitan Hospital, north end of Welfare Island. Another 1,000 bed institution for chronic diseases is contemplated as a section north of Queensboro bridge. These two, when completed, will provide (for) the use of Goldwater Memorial Hospital for 'research' in chronic diseases, its original intention. All of Welfare Island will then be devoted to the care and to the research for better treatment of the chronically ill.

The New York City municipal hospital system also includes facilities for cancer control and tuberculosis, the details of which have been discussed in the previous chapter. Separate facilities are not maintained for orthopedic cases, this service being provided by the general hospitals.

Table 5. Out-Patient Service of New York City Municipal Hospitals, 1944

Type of service	Number of visits
General medical	442,638
Special medical	
Tuberculosis	48,388
Venereal disease	86,730
Other special	81,076
General surgical	178,969
Special surgical	99,490
Obstetrics & gynecology	108,018
Pediatric	78,887
Psychiatric	19,493
Dental	64,422
Ancillary services ^{a/}	286,251
Total	1,494,362

^{a/} X-ray diagnosis, basal metabolism, electrocardiogram, physiotherapy, radiotherapy, hyperthermy, etc.

In conjunction with the operation of the municipal hospitals, the New York City Department of Hospitals conducts out-patient clinics at all of these institutions except the contagious disease hospitals.^{8/} The out-patient departments in 1944 treated a total of 247,430 medically indigent persons, who made an average of 6 visits each. The cost per visit varied from \$0.17 at Coney Island to \$1.32 at Triboro and \$1.41 at Wel-

fare Island Dispensary, with an overall average of \$0.77. The average cost per person varied from \$1.28 at Coney Island to \$18.02 at Triboro.^{9/}

^{8/} The out-patient work of the City, Metropolitan, Goldwater and New York Cancer hospitals is handled through the Welfare Island Dispensary.

^{9/} The cost per individual at Triboro (a tuberculosis institution) is highest since per visit cost for tuberculosis is high and a greater number of treatments per patient (an average of 13.5) are required in this service.

The total cost of out patient service in 1944 was \$1,142,800, all of which was paid by the City of New York. The relatively low per visit and total cost is due in part to the fact that physicians and others voluntarily contribute a large amount of time to the clinics.

The Department of Hospitals reports that:

The Out-patient Department has never been adequately covered from an ideal standpoint since nearly all the service is purely voluntary. During the past four years of our war effort, great difficulty has been experienced in servicing these various divisions of the Out-patient Department, even the ancillary departments which are more definitely a salaried activity.

During the past ten years some services have been covered by the so-called per person group, \$5.00 per session, a minimum requirement of two hours. These have been limited, however, to venereal disease, tuberculosis and the eye (lens testing) for prescription glasses.

The entire Out-patient Department census has diminished greatly, in many instances to approximately one-half of the usual figures. This incidence seems to be general, however, and not confined to our own municipal hospitals in New York City.

Ambulance service. This is a minor item in medical care, but one which is provided to a great extent from public funds. Data are available only for New York City, where ambulance service is provided by the City Department of Hospitals, as authorized by Section 383 of the City Charter. Prior to the war internes were stationed on ambulances, but at the present time specially trained attendants are employed. If the call warrants, an ambulance surgeon is dispatched, and nurses are assigned on psychopathic cases.

In 1944 the Department of Hospitals had 70 ambulances of which 58 were always available for service, the remainder being held in reserve. Ambulance calls in that year totalled 112,457, distributed as follows: 80,981 patients removed to hospitals, 3,793 dead on arrival, 11,868 treated not removed, 4,775 unnecessary, 10,028 transfers between hospitals, and 1,012 taken home or otherwise disposed of.

The cost of this service totalled \$690,978, an average of \$6.15 per call, all of which was paid for by the City. The cost is included in the in-patient service expenditures of the City hospitals. In addition, the City granted \$348,116 to non-municipal institutions toward the cost of maintaining ambulance service.

The Department of Hospitals appraised this service as follows:

Since the beginning of the war our personnel has been altered. Attendants specially trained in patient care, first aid and emergency mechanical appliances have replaced the usual doctor-intern, 'Ambulance Surgeon'. This arrangement, we believe, has been a

distinct service improvement since these ill patients are brought directly to the hospital for examination and disposition by the Examining Physician. Emergency Medical Units have been organized as a supplement to the immediate ambulance service in operation for any catastrophe. The usual personnel of each unit is 2 doctors, 2 trained nurses and 2 trained attendants with 2 stretcher bearers.

Public Welfare Medical Programs

New York State's public assistance program, which has included medical care since 1687, classifies medical care as a necessity of life and affirms it as a right, not only of the individual who is dependent upon the community for items such as food, shelter and clothing, but also for him who is able to supply himself with these necessities but who is unable to purchase needed medical care.

The public welfare program falls into the following categories, which differ according to the type of persons served, the source of funds and, to some extent, the local agency responsible for administration:

Old Age Assistance. Food, shelter and clothing, etc., and medical, nursing and temporary hospital care for needy persons 65 years and over who have one year's residence in the State.

Aid to the Blind. Food, shelter and clothing, etc., and medical, nursing and temporary hospital care for needy blind persons who have one year's residence in the State.

Aid to Dependent Children. Food, shelter and clothing, etc., and medical, nursing and temporary hospital care^{10/} given to needy children under 16 years of age, or between 16 and 18 if attending school, who are living with a parent or other relative and who have one or both parents dead, disabled or absent from the home, and who have one year's residence in the State.

Home Relief. Food, shelter and clothing, etc., and medical and nursing care, but not hospital care, for needy persons not classified as above and who are not inmates of hospitals or other institutions.

Veteran Assistance. Home relief administered by a veteran agency under the Social Welfare Law.

Medical Care only. Medical, dental and nursing care furnished to persons investigated and found to be eligible under home relief standards.

Hospital Care only. Hospitalization in public or private hospitals at public expense for persons not necessarily qualifying under home relief standards, but who are unable to pay in whole or in part for hospital care.

Public assistance may be in the form of cash grants given to individuals or families to enable them to purchase their own necessities, or

^{10/} Temporary hospital care has been available since July 1, 1945.

in the form of goods and services furnished upon the authorization of and paid for by the welfare officer. Except where Federal reimbursement is involved (see Table 7), medical and hospital care are usually provided as services rather than as cash grants ^{11/} Financial responsibility for assistance and care depends upon the "settlement" of the applicant. "Settlement" is acquired by residing one year in a town or city within the State without receiving public assistance or care. Persons having "settlement" in a town or city other than that in which they are found when in need of assistance or care, have the cost of such assistance or care charged back to the district of "settlement." If they have no "settlement" in New York State they become State charge cases and the cost of their assistance or care is charged back to the State.

Few, if any, of the welfare medical programs provide complete service, because they are designed to supplement the services available through private charitable agencies such as hospital out patient departments, and through official agencies such as health and mental hygiene departments which tend to have a broader scope and somewhat more liberal eligibility requirements than the public assistance programs ^{12/} Until the economic depression of the early 1930s, medical care was a relatively minor function of welfare agencies, but it has since become more and more important and, as a result, the authorization and provision of medical care have become rather highly organized. Among the reasons for its increased importance is the fact that during the depression years the resources of private charitable agencies and the ability of physicians to give care without payment proved inadequate to the great demands made upon them. In many instances welfare departments found it necessary for the first time to pay, although often at rates less than standard or actual cost, for hospital, clinic and physicians' services, and this tendency to look to public assistance agencies rather than to private individuals or charitable agencies for medical care has persisted. Although many services are still provided free or at low cost to the needy by private medical agencies, this is often more in the interest of obtaining patients for the instruction of medical students, internes and nurses than for charitable purposes; the trend seems

^{11/} The method and necessity of providing medical care through cash grants is described later in this section.

^{12/} "Medical care as defined herein shall be provided by public welfare officials in accordance with rules of the Department, which shall require full and proper use of existing public and private medical and health facilities and services." - Rules of the State Board of Social Welfare.

to be steadily toward payment at adequate rates for all services rendered to persons eligible for or in receipt of public assistance.

Another influencing factor is the reimbursement granted to local governments by the State and Federal governments. Where the local government is the sole source of funds it has been the tendency, at least in the larger cities, to provide service to residents through public hospitals, clinics and physicians on the basis of a rough and rather flexible sort of means test, without classification of the recipients as public assistance cases. However, as State and Federal reimbursement have entered the picture, the fact that it is granted only for expenditures on behalf of persons found eligible upon rigorous financial investigation has resulted in the practice of one local governmental agency, perhaps a public hospital, clinic, or health department, charging another local governmental agency, the welfare department, for services rendered to public assistance recipients, in order that the locality may receive State and Federal reimbursement. This has helped to shift expenses from localities, whose limited taxing powers are usually confined to taxes on real estate, to the State and Federal governments, which have methods of obtaining revenues which are less direct and less burdensome to individual taxpayers.

In recent years more and more public assistance has been provided as cash grants rather than service, in order that the recipient should not passively receive goods and services as charity, and lose the freedom and responsibility of exercising prudence and judgment in providing for his own needs from a cash allowance. An extension of this philosophy has been to provide the recipient with a special cash grant, when needed, to meet the cost of medical care. Although it seems to be a good practice as applied to predictable expenditures, such as those for food, shelter and clothing, it is not entirely suitable when applied to medical care because it is impossible to predict the medical needs of a person or family; only when costs are averaged over a large group will fixed monthly payments suffice. Federal reimbursement is available only when the recipient received free and unrestricted use of such special cash grant. However, even though medical needs may be met by issuance of special cash grants to recipients, there are still some drawbacks apparent in the difficulty of collection by the physician or other agency. Physicians are unsympathetic with this arrangement because they cannot be assured of prompt or complete payment for services rendered, although their attitude seems to be inconsistent with their preference that under

a public program such as the Emergency Maternity and Infant Care program, cash payments should be made to the recipient of service rather than to the physician or hospital.

Until recent years the decision as to the necessity for granting medical care rested solely with the local welfare official, possibly a person elected to the post for the purpose of keeping down expenditures rather than for his knowledge of the medical needs of people. In some instances this resulted in hardships for indigent persons who were denied necessary medical care. Often, the initial savings resulting from this policy were overbalanced by large expenditures at a later date because of delayed treatment leading to prolonged care, chronic invalidism, or long term dependency of family members due to death of the wage earner. Also, the lay welfare officer has often expended public money unnecessarily for periods of hospitalization longer than actually required, or for worthless appliances, patent medicines, etc., because of his lack of medical knowledge.

To correct the first of these faults the Social Welfare Law was amended in 1940, on the recommendation of the New York State Commission to Formulate a Long Range Health Program, to provide that "the determination as to medical care necessary for any person shall be made with the advice of a physician".^{13/} Earlier, about 1936, for the same purpose and also to promote the efficient expenditure of public moneys and to avoid the delays and expense attendant upon referring to a central State agency for authorization of many types of medical care for which State reimbursement was desired, city and county welfare districts were urged to employ full or part time medical directors to keep accurate medical records, to make a study of all community resources which might be utilized before employing welfare funds for medical care, and to formulate a definite medical care program to be administered under written rules.^{14/} This idea has caught on to the extent that today a majority of the State's population reside in public welfare districts having medical directors and State approved medical programs (see Table 6). This makes it possible to obtain State reimbursement for medical care provided at varying rates and by methods of payment suited to local conditions, and is an excellent example of what can be accomplished through decentralization of administration to the local level.

^{13/} Section 184, Social Welfare Law.

^{14/} For a description, see "New York State's Public Medical Care Program", Lee C. Dowling, Public Welfare, Feb. 1944.

Table 6. Status of Local Medical Care Plan Development,
February 1946

Medical plans completed and installed	Medical plans in process of development
Buffalo Area	
Orleans County Erie County Cattaraugus County Wyoming County City of Lockport City of Jamestown Chautauqua County	Niagara County Wyoming County
Rochester Area	
Steuben County Allegany County Wayne County Yates County Schuyler County Monroe County Towns of Steuben County Rochester City Livingston County	Seneca County Yates County
Syracuse Area	
Oneida County Herkimer County Chenango County Broome County City of Binghamton Onondaga County	Town of Union Oneida Co. BCW <u>a/</u> City of Utica Oswego County Utica Veterans Bureau
Albany Area	
Clinton County Essex County Otsego County Rensselaer County City of Troy Warren County Schenectady County City of Plattsburg Washington County Fulton County Saratoga County Saratoga County BCW <u>a/</u> Franklin County	
New York Area	
Nassau County Suffolk County Westchester County Putnam County Dutchess County City of New Rochelle Orange County	Rockland County City of Newburgh Ulster County
New York City	
New York City	

a/ Board of Child Welfare

Elsewhere, medical care is usually given under uniform State rules regarding fees,^{15/} the incentive to abide by such rules being that reimbursement cannot be obtained without compliance. The pattern seems to be that where there is no State reimbursement, for example, in the case of hospital care, expenditures tend to be through official agencies other than welfare departments, but it appears that as the scope of reimbursement is widened the State will eventually extend its control to cover all types of medical care.

The percentage of reimbursement by State and Federal governments for medical care rendered to public assistance recipients is shown in Table 7. It is possible that the percentage of State reimbursement to localities may be increased to 80 per cent in accordance with recommendations made to the Legislature by the Commission on Municipal Revenues and Reduction of Real Estate Taxes, although it is understood that there will be no State reimbursement for hospital care only.

Table 7. Federal and State and Local Participation in Expenditures for Welfare Medical Services

Program	Type of care	Percentage of financial participation ^{a/}		
		Local	State	Federal
Home Relief & Veteran Assistance ^{b/}	Hospital only	100	0	0
Home Relief & Veteran Assistance ^{b/}	Medical only	60	40	0
Old Age Assistance ^{c/d/}	Medical & hospital ^{g/}	25	25	50
Assistance to the Blind ^{c/d/}	Medical & hospital ^{g/}	25	25	50
Aid to Dependent Children ^{f/e/}	Medical & hospital ^{g/}	50	0	50
Non-relief, needy	Hospital only	100	0	0

^{a/} Exclusive of administrative costs, to which a different formula applies.

^{b/} Includes cases admitted to relief status for medical care only.

^{c/} For grants made directly to recipient; if payment is made to physician or hospital by welfare agency, Home Relief formula applies.

^{d/} Federal financial participation does not continue beyond 50 per cent of total monthly budget of \$40 for medical care and all other kinds of assistance. Formula then becomes 25 per cent local and 75 per cent State.

^{e/} Federal financial participation does not continue beyond 50 per cent of total monthly budget of \$18 for first child and \$12 for each additional child. Formula then becomes 50 per cent local and 50 per cent between Federal and State, the latter assuming the share of the 50 per cent in which there is no Federal participation.

^{f/} For grants made directly to recipient; if payment is made to physician, hospital etc. by welfare agency, formula is 50 per cent local and 50 per cent State.

^{g/} Hospitalization in county or municipal hospital, or for more than 6 months in any other hospital, is considered institutional care and is excluded from State and Federal participation.

Special study of current expenditures In cooperation with the Commission on Medical Care, the State Department of Social Welfare undertook to determine the cost of care furnished directly to individuals through State and local departments of welfare. Detailed records of all medical expenditures kept by the welfare departments during April, May and June 1945 form the basis for the figures presented herein. They have been adjusted to an annual basis for convenience of comparison and interpretation. This is perhaps the most ambitious study of its kind ever undertaken, and it presents a more complete picture than has previously been available. Many items of interest which it has not been possible to present here because of limitations of space are contained in the detailed records of the study on file in the State Department of Social Welfare.

As pointed out previously, the welfare medical programs supplement other public and private programs and, in some instances, do not attempt to supply certain types of service. In New York City, for example, physicians' services in the office are not covered, and the welfare client must depend on the clinics of the private hospitals and the New York City Department of Hospitals for this type of service. The New York City Department of Welfare does not pay physicians for surgery performed in hospitals, dental care is limited to that provided in four clinics conducted by the Department, and ambulance service is covered by the City Department of Hospitals; also, it is not their policy to accept cases requiring assistance for medical care only, with the exception of hospital care for State charges. In the rest of the State the completeness of service varies according to locality. Orthopedic, mental hygiene, child health, dental, cancer, child guidance and other clinics conducted by such official agencies as the State Departments of Health and Mental Hygiene, and local departments of health, hospitals and education, are utilized. In addition, private agencies such as hospitals, the National Foundation for Infantile Paralysis, and visiting nurse associations, provide services which relieve welfare departments of making expenditures. The practice of paying physicians varies by rate and type of service, most localities not undertaking to pay physicians for surgical services provided in hospitals.

In respect to the hospital care of tuberculosis patients, welfare departments, and counties and cities as such, may have overlapping responsibilities. As a rule, most of the cost of hospitalization of the tuberculous is a charge directly on the county or city. Relatively little is paid for from welfare department funds. In venereal disease treatment

there is a dual responsibility of health and welfare departments, but it is believed that the greater part of this expense is now borne by the health departments. The care of communicable diseases was formerly the responsibility of health departments, but owing to a change in the Social Welfare Law some years ago, the cost may now be borne by welfare departments.

Expenditures. As shown in Table 8, the current estimated annual expenditure was slightly in excess of \$10 million, being \$1.7 million for New York City and \$8.3 million for the rest of the State. The reason for the lower expenditure in New York City was due chiefly to the much greater amount of care provided through the public hospitals in that city than through public hospitals in the rest of the State. However, after deducting surgeons' fees, nursing in the hospital, hospitalization, nursing-home care, clinic service and ambulance (see Table 10) the two areas still showed a difference - New York City \$0.67 million, and the rest of the State \$1.8 million. About two-thirds of the difference seems to lie in general practitioners' services. A part of this difference may be attributable to the fact that the services corresponding to physician's office calls that are paid for chiefly from public welfare funds in the State outside of New York City, are provided through public clinics in New York City. Some of the difference lies in the lower expenditures for drugs and appliances in New York City, and some of it may be due to the failure of the New York City program to provide physicians' services in the home for the medically needy who are not otherwise eligible for public assistance. It seems possible that expenditures in the latter category might help to reduce the volume of hospitalization at public expense in New York City, and at the same time improve the quality of service.

Of the various categories, Old Age Assistance cases required the largest sum, about \$4 million, followed by Hospital Care only - \$2.4 million, and medical care for Home Relief cases - \$1.95 million. Aside from the Hospital Care only program, relatively little was expended from public welfare funds for the care of persons otherwise able to provide for themselves; nothing was spent in New York City and only \$155,800 in the rest of the State. Of the total of \$10 million, \$6.2 million came from local funds, \$3 million from State funds, and \$0.8 million from Federal funds.

The cost of administration has been estimated on the basis of sample studies in a few representative welfare districts, and an estimate of the time required by the medical programs in relation to the time required

Table g. Summary of Expenditures from Public Welfare Funds for General Medical Care by Public Welfare Agencies, Classified by Programs of Assistance

Program	Source of funds			
	Local	State	Federal	Total
New York City				
Old Age Assistance	\$322,332.00	\$274,352.00	\$23,964.44	\$1,290,699.04
Aid to the Blind	3,092.00	6,297.76	3,155.92	12,545.68
Aid to Dependent Children	64,633.82	57,592.98	10,043.48	132,270.28
Home Relief, regular	150,267.40	104,357.15	0	255,224.96
" " medical care only	0	0	0	0
Hospital care only	0	0	0	0
Tuberculosis hospitalization	0	0	0	0
County home & infirmary	0	0	0	0
Foster homes & institutions	0	0	0	0
Total	510,975.22	1,442,599.90	127,163.24	1,690,739.96
Rest of State				
Old Age Assistance	\$825,950.12	\$1,373,725.72	\$642,904.96	\$2,702,580.80
Aid to the Blind	14,863.08	74,078.24	11,230.20	60,178.72
Aid to Dependent Children	88,534.98	46,662.70	28,060.08	163,257.76
Home Relief, regular	1,302,170.36	236,207.20	0	1,539,386.56
" " medical care only	136,047.60	19,756.64	0	155,804.24
Hospital care only	2,148,388.44	206,979.44	0	2,355,367.88
Tuberculosis hospitalization	437,366.24	53,468.20	0	491,033.84
County home & infirmary	725,975.84	1,669.28	0	727,645.12
Foster homes & institutions	136,404.12	5,692.24	0	142,096.36
Total	5,676,915.12	1,978,140.36	682,195.24	8,337,251.28
Entire State				
Old Age Assistance	\$1,008,132.72	\$2,747,077.72	\$736,869.40	\$3,993,279.84
Aid to the Blind	17,963.08	40,376.60	14,386.72	72,724.40
Aid to Dependent Children	153,162.80	104,259.58	38,103.56	295,528.04
Home Relief, regular	1,454,047.16	240,264.36	0	1,794,611.52
" " medical care only	136,047.60	19,756.64	0	155,804.24
Hospital care only	2,148,388.44	206,979.44	0	2,355,367.88
Tuberculosis hospitalization	437,366.24	53,468.20	0	491,033.84
County home & infirmary	725,975.84	1,669.28	0	727,645.12
Foster homes & institutions	136,404.12	5,692.24	0	142,096.36
Total	6,217,891.40	3,020,840.16	780,359.68	10,028,091.24

a/ Monthly sum included in general grant, to be expended for medical care as needed

Table 9. Estimated Costs of Administration of General Medical Care Provided by Public Welfare Agencies

Program	Source of funds			
	Local	State	Federal	Total
New York City				
Old Age Assistance	\$47,727.33	\$31,818.22	\$15,909.11	\$95,454.66
Aid to the Blind	994.51	0	994.51	1,989.02
Aid to Dependent Children	12,976.83	0	12,976.83	25,953.66
Home Relief	26,348.38	17,565.60	0	43,913.98
Hospital care only	0	0	0	0
Tuberculosis hospitalization	0	0	0	0
County home & infirmary	0	0	0	0
Foster homes & institutions	0	0	0	0
Total	88,047.05	49,383.82	29,880.45	167,311.32
Rest of State				
Old Age Assistance	\$196,151.47	\$130,767.54	\$65,323.82	\$392,302.93
Aid to the Blind	2,740.80	0	2,740.79	5,481.59
Aid to Dependent Children	19,226.04	0	19,226.03	38,452.07
Home Relief	97,877.20	65,251.46	0	163,128.66
Hospital care only	149,766.11	99,245.74	0	249,611.85
Tuberculosis hospitalization	14,731.10	0	0	14,731.10
County home & infirmary	29,105.80	0	0	29,105.80
Foster homes & institutions	4,262.88	2,841.92	0	7,104.80
Total	513,821.40	292,706.76	87,350.64	899,918.80
Entire State				
Old Age Assistance	\$243,878.80	\$162,535.26	\$81,292.89	\$487,757.59
Aid to the Blind	3,735.31	0	3,735.30	7,470.61
Aid to Dependent Children	32,202.86	0	32,202.87	64,405.73
Home Relief	124,225.58	82,317.06	0	207,042.64
Hospital care only	149,766.11	99,245.74	0	249,611.85
Tuberculosis hospitalization	14,731.10	0	0	14,731.10
County home & infirmary	29,105.80	0	0	29,105.80
Foster homes & institutions	4,262.88	2,841.92	0	7,104.80
Total	601,908.44	343,990.62	117,231.06	1,067,230.12

for administration of all phases of public assistance. The overall cost, as shown in Table 9, was \$1,067,000 or about 10 per cent of the cost of services provided, of which \$602,000 came from local funds, \$348,000 from State funds and \$117,000 from Federal funds.

In Table 10 medical welfare expenditures are broken down into types of service, as well as sources of funds.

Table 11 shows for the various relief categories the average number of persons receiving public assistance during the year, i.e., the person-years. In the Old Age Assistance and the Aid to the Blind cases there is relatively little turnover in the course of a year, but in the Aid to Dependent Children, and the Home Relief cases, where assistance may be granted for only short periods of loss of income due to illness, etc., the turnover is great.

Some idea of the cost of providing medical care to certain age groups in the population may be obtained for programs where all, or nearly all, of the medical care received is provided from public welfare funds. The following data apply only to the State outside of New York City because in New York City a great amount of medical care is provided at public expense from other than public welfare funds. The cost of administration, which would add an extra 10 per cent, is not included. Dividing the \$2,702,581 cost of care for Old Age Assistance cases in the State outside of New York City by the 53,106 person-years in this category yields an annual per capita cost of approximately \$51 for medical care of persons aged 65 years and over, at public welfare rates. The corresponding figure for Aid to the Blind is \$55 per capita. It is emphasized that these are not the costs per person receiving medical care; they are the average per capita costs for the entire group, some of whom received medical care, and some of whom did not. These figures would seem to be representative of the per capita cost of meeting the outstanding needs of the older population groups if service were purchased at reduced rates and full advantage were taken of private charitable resources. The per capita cost under Home Relief is \$73 per year in cases which received assistance for food, shelter or clothing, etc.; cases which received only medical care under the Home Relief program have been excluded. The extent to which this figure is increased by the fact that many recipients found it necessary to request public assistance only because of acute or chronic illness in the wage earner (approximately 50 per cent in 1944), is cancelled to some extent by the fact that for the Home Relief cases, hospital care was not a reimbursable

Table 10. Summary of Expenditures from Public Welfare Funds for General Medical Care
by Public Welfare Agencies, Classified by Types of Service

Type of service	Source of funds			
	Local	State	Federal	Total
New York City				
General practitioners:				
Salaried basis	0	0	0	
Fee basis	\$96,406.60	\$24,802.80	\$62,474.60	\$243,684.00
Surgery	0	0	0	0
Specialists	461.36	462.08	21.68	945.12
Refractions	1,486.16	2,110.72	0	3,596.88
Dental care	39,527.80	45,213.80	0	84,741.60
Nursing care:				
In patient's home	7,966.40	7,873.44	7,848.16	23,688.00
In hospital	0	0	0	0
Nursing home care	32,348.60	30,902.28	31,739.88	94,990.76
Drugs and medical supplies	87,950.48	122,943.12	0	210,893.60
Prosthetic appliances:				
Eyeglasses	15,005.48	20,985.80	0	35,991.28
Dentures	20,541.26	29,258.66	0	49,799.92
Other services	9,817.08	9,652.20	5,079.52	24,548.80
Hospitalization	229,465.00	688,395.00	0	917,860.00
Clinic visits	0	0	0	0
Ambulance services	0	0	0	0
Other medical services	0	0	0	0
Total	540,976.22	1,042,599.90	107,163.84	1,690,739.96
Rest of State				
General practitioners:				
Salaried basis	\$102,461.00	\$69,805.40	\$5,949.36	\$178,215.76
Fee basis	309,366.76	277,533.84	301,354.68	888,255.28
Surgery	67,490.64	22,441.52	6,553.64	96,485.80
Specialists	13,167.44	6,782.56	4,864.56	24,814.56
Refractions	7,321.60	5,216.72	4,898.28	17,436.60
Dental care	31,497.48	13,120.64	8,937.32	52,650.44
Nursing care:				
In patient's home	27,748.84	27,106.52	17,529.80	72,385.16
In hospital	104,115.00	6,546.32	6,295.52	116,956.84
Nursing home care	249,172.00	250,713.48	244,335.68	744,221.16
Drugs and medical supplies	138,531.92	185,910.24	28,014.76	352,456.92
Prosthetic appliances:				
Eyeglasses	21,078.32	19,724.92	11,156.04	51,959.28
Dentures	15,511.90	14,399.46	11,412.68	41,324.04
Other services	27,785.12	13,985.32	3,215.32	44,986.76
Hospitalization	4,397,575.20	1,024,903.84	22,997.08	5,445,476.12
Clinic visits	34,354.28	12,533.08	1,293.64	48,181.00
Ambulance services	35,837.92	12,965.44	895.92	49,699.28
Other medical services	93,899.76	14,550.96	3,395.56	111,846.28
Total	5,676,915.18	1,978,240.26	682,195.84	8,337,351.28
Entire State				
General practitioners:				
Salaried basis	102,461.00	69,805.40	5,949.36	178,215.76
Fee basis	405,773.36	362,336.64	363,829.28	1,131,939.28
Surgery	67,490.64	22,441.52	6,553.64	96,485.80
Specialists	13,628.80	7,244.64	4,886.24	25,759.68
Refractions	8,807.76	7,327.44	4,898.28	21,033.48
Dental care	71,025.28	58,334.44	8,032.32	137,392.04
Nursing care:				
In patient's home	35,715.24	34,979.96	25,377.96	96,073.16
In hospital	104,115.00	6,546.32	6,295.52	116,956.84
Nursing home care	281,520.60	281,615.76	276,075.56	839,211.92
Drugs and medical supplies	226,482.40	308,853.36	28,014.76	563,350.52
Prosthetic appliances:				
Eyeglasses	36,083.80	40,710.72	11,156.04	87,950.56
Dentures	36,053.16	43,658.12	11,412.68	91,123.96
Other services	4,637,602.20	23,637.52	8,295.84	69,535.56
Hospitalization	27,040.20	1,713,298.84	22,997.08	6,363,336.12
Clinic visits	34,354.28	12,533.08	1,293.64	48,181.00
Ambulance services	35,837.92	12,965.44	895.92	49,699.28
Other medical services	93,899.76	14,550.96	3,395.56	111,846.28
Total	6,217,291.40	3,020,840.16	789,359.68	10,028,091.24

Table 11. Movement of Public Assistance Cases, November 1944 - October 1945.								
Movement of cases	Old Age Assistance		Aid to Blind		Aid to Depend- ent Children		Home Relief	
	New York City	Rest of State	New York City	Rest of State	New York City	Rest of State	New York City	Rest of State
Cases Nov. 1, 1945	53,007	54,089	1,805	1,097	13,863	4,770	27,799	11,195
Added during year	7,810	8,203	530	158	8,408	3,277	14,183	11,810
Closed during year	9,293	10,168	448	167	5,195	2,063	18,152	12,974
Average for year ^{a/}	52,266	53,106	1,846	1,093	15,470	5,376	25,792	10,613
Av. persons per case	1	1	1	1	2.16	2.63	1.78	1.99
Person-years ^{b/}	52,266	53,106	1,846	1,093	33,477	14,160	45,910	21,120

^{a/} Number at beginning of year plus one-half the number added, less one-half of the number closed.

^{b/} Product of average number of cases under care during year and average number of persons per case.

item and may have been provided by public hospitals rather than at welfare department expense.

The figure for Aid to Dependent Children recipients is only \$11.50. This may be an understatement in respect to hospital care for the same reasons that apply to Home Relief cases^{16/}; also, some health supervisory, orthopedic and related services may have been provided through health department and related programs other than those conducted by welfare departments. Another interpretation may be that, relatively speaking, the welfare medical programs do not offer as much for children as for older persons, possibly because the medical needs of children are less obvious and require care which is preventive rather than restorative in nature.

The percentage distribution and the dollar cost of the various types of medical service are shown in Table 12. The distribution of average per capita expenditures is quite similar for Old Age Assistance and Aid to Blind cases. In these groups there are undoubtedly many cases of chronic disease necessitating rather large expenditures for hospital care, nursing home care and nursing care in the patient's own home. Aid to Dependent Children cases require relatively small expenditures from welfare funds, so small in fact that after allowance has been made for services available to them through other agencies and the fact that relatively low fees are paid for service, it appears that this group may be receiving a volume of care which does not meet their needs. The small expenditures for dental care are worthy of comment, since adequate care would entail amounts greatly in excess of those shown in Table 12. Under Home Relief, hospital care makes up a large proportion of total expenditures despite the fact that the figures do not include a large volume of care paid for by agencies other than welfare departments. Relatively more physician care is provided on a salary than on a fee basis for this group; also, expenditures for dental care and eye refractions are low. The limitations of these data in respect to affording a judgment of the adequacy of care have been pointed out; more extensive conclusions concerning the adequacy of medical care for relief cases in general would not seem warranted in view of these limitations and the fact that the scope of the Commission's studies did not afford a more thorough study of this subject.

^{16/} Hospital care for these cases did not become a reimbursable item until July 1, 1945, which was after the period of this survey.

Table 12. Percentage Distribution, and Average Annual Per Capita Medical Cost for Public Assistance Recipients, New York State, Exclusive of New York City, 1945 ^{a/}

Type of service	Per cent distribution				Average cost per capita			
	CAA	AB	ADC	HR ^{b/}	CAA	AB	ADC	HR ^{b/}
Physician services								
Gen'l practitioner, salary	2.9	1.1	3.9	3.8	\$ 1.49	\$.60	\$.45	\$ 2.73
Gen'l practitioner, fee	24.9	19.0	33.1	5.8	12.67	10.48	3.81	4.21
Surgery	1.1	1.0	2.1	1.3	.58	.56	.24	.95
Specialist	.4	.5	1.6	.3	.21	.25	.19	.19
Refraction ^{c/}	.4	.2	1.9	.1	.18	.13	.22	.09
Clinic visit	.6	.4	1.0	.8	.28	.20	.12	.56
All physician care	30.3	22.2	43.6	12.1	15.41	12.22	5.03	8.73
Dentistry								
Dental care	.3	1.2	12.1	.4	.16	.65	1.40	.31
Dentures	.9	.6	4.0	.5	.46	.35	.45	.32
All dental care	1.2	1.8	16.1	.9	.62	1.00	1.85	.63
Hospitalization								
All hospital care	33.7	36.7	16.9	71.2	17.18	20.22	1.95	51.93
Nursing care								
At home	2.1	1.7	.6	.3	1.07	.90	.07	.26
In hospital	.6	.2	-	.1	.31	.12	-	.07
All nursing care	2.7	1.9	.6	.4	1.38	1.02	.07	.33
Nursing home								
Nursing home care ^{d/}	20.6	28.6	.2	8.9	10.46	15.76	.03	6.52
Drugs and appliances								
Drugs and supplies	8.4	6.9	13.8	3.9	4.29	3.81	1.58	2.87
Eye-glasses	1.2	.1	4.9	.5	.59	.07	.56	.33
Appliances (except dental)	.6	.9	2.1	.8	.31	.48	.25	.61
All drugs and appliances	10.2	7.9	20.8	5.2	5.19	4.36	2.39	3.81
Miscellaneous								
Ambulance	.6	.5	.2	.8	.28	.25	.02	.55
Other	.7	.4	1.6	.5	.37	.23	.19	.39
All miscellaneous	1.3	.9	1.8	1.3	.65	.48	.21	.94
Total								
All medical care	100.0	100.0	100.0	100.0	50.89	55.06	11.53	72.89

^{a/} Based on three month period, April, May and June.

^{b/} Includes only Home Relief cases receiving assistance such as food, clothing and shelter; does not include cases opened for medical care only.

^{c/} Refraction by physician, optometrist or ophthalmologist.

^{d/} Care of the sick, chiefly chronic cases, in suitable places other than hospital or patient's home.

Local Expenditures for General Medical Care

In obtaining revenues for a State medical insurance program, localities might be required to contribute to the State insurance fund in view of the fact that the State program would relieve them of customary medical care expenditures. Because medical needs are relatively constant from locality to locality, the contributions required of localities might be on a per capita basis. As an alternative, the contributions might be

Table 13. Estimated Annual Local Expenditures for Medical Care Exclusive of Tuberculosis Hospitalization,^{a/} Provided by Local Welfare Departments and Public General Hospitals, 1944-45. State and Federal Funds Have Been Excluded.

County	Welfare medical expenditures local funds b/	Estimated additional public hospital expenditures c/	Total local expenditures	1945 population	Per capita expenditure	Equalized assessed value (thousands)	Expenditure per \$1000 assessed value	Assessed value per capita
Albany	\$ 193,331	\$ -	\$ 193,331	227,688	\$.85	\$ 356,514	\$.54	\$1,566
Allegany	25,499	6,600	32,099	39,585	.81	63,896	.50	1,614
Broome	124,147	147,500	271,647	175,301	1.55	211,899	1.28	1,209
Cattaraugus	37,210	1,000	38,210	68,819	.56	81,290	.47	1,181
Cayuga	13,555	-	13,555	62,928	.22	80,255	.17	1,275
Chautauque	46,250	39,500	85,750	123,297	.70	157,810	.54	1,280
Chemung	62,400	-	62,400	81,043	.77	94,628	.66	1,168
Chenango	9,006	-	9,006	37,336	.24	32,676	.28	875
Clinton	45,949	-	45,949	43,277	1.06	39,078	1.18	903
Columbia	18,919	-	18,919	37,739	.50	53,122	.36	1,408
Cortland	14,938	-	14,938	32,346	.46	31,741	.47	981
Delaware	29,112	0	29,112	37,048	.79	43,493	.67	1,174
Dutchess	89,439	-	89,439	106,896	.84	166,836	.54	1,561
Erie	415,728	550,000	965,728	856,342	1.13	1,323,162	.73	1,545
Essex	63,871	7,494	71,365	31,335	2.28	47,951	1.49	1,530
Franklin	57,181	-	57,181	44,122	1.30	51,008	1.12	1,156
Fulton	34,153	-	34,153	48,241	.71	55,562	.62	1,152
Genesee	21,378	-	21,378	44,750	.48	60,975	.35	1,363
Greene	26,768	0	26,768	26,878	1.00	33,785	.79	1,257
Hamilton	1,208	-	1,208	3,413	.35	21,649	.06	6,343
Herkimer	16,048	-	16,048	61,411	.26	85,768	.19	1,397
Jefferson	95,103	17,050	112,153	83,630	1.34	99,877	1.12	1,194
Lewis	3,812	13,768	17,580	21,509	.82	26,800	.66	1,246
Livingston	26,750	-	26,750	33,761	.79	49,733	.54	1,473
Madison	8,921	6,500	15,421	40,935	.38	42,472	.36	1,037
Monroe	1,130,100	297,310	1,427,410	450,285	3.17	715,115	2.00	1,588
Montgomery	29,638	-	29,638	57,876	.51	70,599	.42	1,220
Nassau	138,415	411,907	550,322	456,225	1.21	1,020,019	.54	2,236
Niagara	53,373	35,500	88,873	179,844	.49	304,569	.29	1,694
Oneida	39,262	288,428	327,690	211,174	1.55	252,280	1.30	1,195
Onondaga	275,091	38,000	313,091	309,827	1.01	434,203	.72	1,401
Ontario	8,692	-	8,692	52,707	.16	80,979	.11	1,536
Orange	70,901	-	70,901	132,142	.54	188,438	.38	1,426
Orleans	19,695	-	19,695	26,963	.73	33,778	.58	1,253
Oswego	41,035	10,800	51,835	68,867	.75	75,850	.68	1,101
Otsego	14,318	-	14,318	44,386	.32	58,482	.24	1,318
Putnam	13,992	-	13,992	15,773	.89	47,337	.30	3,001
Rensselaer	108,692	-	108,692	120,880	.90	140,062	.78	1,159
Rockland	17,932	-	17,932	63,060	.29	103,371	.17	1,639
St. Lawrence	39,462	27,000	66,462	90,535	.73	98,463	.67	1,088
Saratoga	56,998	-	56,998	67,150	.85	105,188	.54	1,566
Schenectady	42,726	34,400	77,126	135,237	.57	231,968	.33	1,715
Schoharie	18,703	-	18,703	20,298	.92	23,139	.81	1,140
Schuyler	11,079	-	11,079	12,421	.89	13,632	.81	1,097
Seneca	21,365	8,648	30,013	24,957	1.20	25,648	1.17	1,028
Steuben	69,472	-	69,472	85,151	.82	85,794	.81	1,002
Suffolk	92,530	-	92,530	194,833	.47	510,555	.18	2,620
Sullivan	31,372	-	31,372	34,568	.91	84,365	.37	2,441
Tioga	16,701	-	16,701	26,831	.62	26,007	.64	969
Tompkins	19,618	-	19,618	43,321	.45	64,252	.31	1,483
Ulster	53,488	-	53,488	81,930	.65	121,673	.44	1,485
Warren	27,450	-	27,450	37,178	.74	68,170	.40	1,834
Washington	46,453	-	46,453	43,328	1.05	39,483	1.15	911
Wayne	28,255	-	28,255	53,557	.53	59,894	.47	1,118
Westchester	1,136,500	38,000	1,174,500	560,951	2.09	1,480,598	.79	2,639
Wyoming	5,652	6,600	12,252	29,415	.42	34,060	.36	1,158
Yates	15,200	-	15,200	16,170	.89	24,378	.62	1,508
State, Excluding New York City	5,173,886	1,986,005	7,159,891	6,117,520	1.17	9,933,828	.72	1,624
New York City	2,293,738 ^{a/}	23,500,000	25,793,738	7,730,383	3.34	14,981,496	1.72	1,938
Entire State	7,467,624	25,486,005	32,953,629	13,847,903	2.38	24,915,325	1.32	1,799

^{a/} In New York City, some expenditures for the care of tuberculosis patients in private hospitals could not be separated from other expenditures.

^{b/} Adjusted to annual basis from figures for April, May and June 1945, or other representative 3-month period.

^{c/} Represents additional expenditures, e.g., receipts of a municipal hospital from public welfare departments have been excluded, insofar as was possible.

based on customary expenditures for medical care of the needy

Table 13 shows local expenditures by welfare departments and public general hospitals. Moneys received from the State and Federal governments, and expenditures for tuberculosis hospitalization, have not been included. The additional expenditures for municipal and county hospitals represent the amounts paid from public general funds after deduction of receipts from public welfare agencies and private individuals and agencies. Care was taken to avoid duplication of figures. Any duplication that might remain would be small in amount and would not detract from the primary purpose of the table, which is to show the variation among localities.

The variation among localities is great, from \$0.16 to \$3.34 per capita, the average in the State outside of New York City being \$1.17, and in New York City \$3.34. The median figure for the State outside of New York City is \$0.79 per capita. On the basis of community wealth, as judged by the equalized assessed valuation of real property, the variation is not as marked, but is still very great. There seems to be no striking relationship between per capita assessed valuation and per capita expenditures for medical care. The public expenditures for medical care seem rather to reflect the operation of several factors: standards of eligibility for care (this is especially noticeable in respect to hospitalization in New York City), volume of care provided, cost per unit of service, and the extent of private philanthropy. There seems to be no correlation between the rate of public expenditures and the percentage of population covered by hospitalization insurance, but it is remarkable that Monroe County, which greatly exceeds any locality except New York City in per capita expenditures from public funds, is the county which greatly exceeds all others in the purchase of hospitalization insurance. This observation suggests that no matter how generously provision is made from public funds, people prefer to purchase medical care from their own resources rather than to rely on public or private charity.

CHAPTER VIII

PUBLIC MEDICAL CARE, CONTINUED

(WORKMEN'S COMPENSATION AND MISCELLANEOUS PROGRAMS)

Workmen s Compensation

Workmen's Compensation laws, which constitute a type of compulsory health insurance widely accepted in the United States, developed from the realization that industrial accidents are an industrial responsibility, and should be considered as a regular cost of production.

Although not paid for from public funds as such, the coverage and expenditures are prescribed by law and, added to the cost of production, affect all residents of the State and may be considered as a public program. Early compensation laws emphasized cash benefits,^{1/} but these were found to be inadequate since medical services necessary for recovery and rehabilitation of the worker were frequently ignored.^{2/} The emphasis has shifted to medical care benefits to the extent that in New York State expenditures for medical care approximate one third of compensation payments, as illustrated in Table 1.^{3/}

In 1944 the Moreland Commission, appointed by the Governor to investigate the administration of Workmen's Compensation, submitted a report revealing many abuses. Its findings are commented on herein, and 1944 and 1945 corrective legislation adopted on the recommendation of the Moreland Commission is indicated by capitals.

Coverage. Insurance against industrial accidents and diseases must be carried for all employees by employers engaged for profit in industries which are designated as hazardous, or which contain occupations designated as hazardous. In non hazardous activities employers may elect insurance. An employee may not waive his rights to compensation or pay any part of premiums. Failure to obtain required insurance is punishable by fine and/or imprisonment.

Comment. A large number of employers fail to secure the necessary insurance. In 1943, 1600 claims cases were filed against non-insured employers, and an additional 1,400 employers were prosecuted for failing to obtain insurance.^{4/} Since 1930, approximately 45 per

^{1/} Cash benefits paid under Workmen's Compensation are not included in this section.

^{2/} Report of the Industrial Survey Commission of New York for 1927-8, Legislative Document (1928) No. 87.

^{3/} It is estimated that 70 per cent of medical care expenditures is paid to physicians and 30 per cent to hospitals.

^{4/} Annual Report of the Industrial Commissioner, 1943.

cent of awards against non-insuring employers have not been paid.^{5/} Because of the several types of insurance permitted, it is difficult to enforce the coverage provisions.

As with any insurance plan based on employment units, considerable confusion has arisen concerning coverage of interstate and maritime operations.

Table 1. Incurred Losses^{a/} of Insurance Companies and the State Fund by Cash and Medical Payments for 1940, 1941 and 1942.^{6/}

Carriers and payments	1940		1941		1942	
	Amount (thousands)	Per cent	Amount (thousands)	Per cent	Amount (thousands)	Per cent
Stock companies						
Cash benefits	\$12,727	67	\$13,962	67	\$16,300	71
Medical benefits	6,413	33	7,016	33	6,724	29
Mutual companies						
Cash benefits	9,385	66	11,155	67	13,309	70
Medical benefits	4,781	34	5,635	33	5,644	30
State Fund						
Cash benefits	10,821	72	11,551	71	10,744	71
Medical benefits	4,245	28	4,639	29	4,220	28
All carriers						
Cash benefits	32,933	68	36,668	68	40,353	71
Medical benefits	15,439	32	17,290	32	16,588	29
Total	48,372	100	53,958	100	56,941	100

a/ Incurred losses consist of losses paid during the period and also the present value of future payments on the claims.

Methods of obtaining insurance. Insurance may be obtained as follows:

1. State Fund. A State Insurance Fund is set up in the Department of Labor to insure employers. It is administered by the Industrial Commissioner and seven persons representing employers insured with the Fund. All administrative costs, not to exceed 25 per cent of premiums, are paid out of the fund. Premiums are fixed at the lowest rate consistent with maintenance of solvency. State Department of Insurance supervision is comparable to that for private insurance companies.
2. Mutual associations or stock companies. Upon payment of an annual fee of 1 per cent of premiums, which fee is deposited in a security fund to pay awards against insolvent companies and costs of administration, insurance companies may obtain a license to sell Workmen's Compensation insurance. A penalty of up to \$2,500 may be imposed for failure to obtain a license. Employers are liable if the company defaults in claims payments. Operations are supervised by the State Department of Insurance.

^{5/} Administration of the Workmen's Compensation Law in the State of New York, Report of the Moreland Commissioners, 1944.

^{6/} Communication from the Compensation Insurance Rating Board, July 31, 1945.

3. Self-insurers.

- a. Private. Employers who furnish proof, to the satisfaction of the CHAIRMAN OF THE WORKMEN'S COMPENSATION BOARD, of their ability to pay compensation and who post a bond, may pay out awards personally with no insurance policy required. The Division of Self-Insurance in the Department of Labor, representing self-insurers, advises the CHAIRMAN OF THE WORKMEN'S COMPENSATION BOARD on questions relating to self insurance. Its expenses are met by assessment of the self-insurers.
- b. Public. By resolution of the board of supervisors a county may insure itself, and a subdivision thereof may join in the county plan for paying the claims and medical costs incurred under the State law, and sharing the costs on the basis of assessed valuation.

Comments. When Workmen's Compensation was first adopted in New York State in 1914, there existed as in other States the situation of many commercial insurance companies firmly entrenched in this field of insurance, who resisted the establishment of a State insurance system; employers who hesitated to approve untried insurance experiments; the lack of public understanding of social insurance^{7/}. As a result, private companies were permitted to operate along with a State fund to insure against the risks of employee accidents. Today it is estimated that New York State coverage of Workmen's Compensation is in the neighborhood of 4 million employees. It is roughly estimated that distribution of these employees between the various methods of coverage is as follows:

Type of coverage	No. of employees
Self insurers	700,000
Governmental	75,000
Non-governmental	625,000
Private companies	2,200,000
State Fund	1,100,000
Total	4,000,000

Of \$115.6 million paid to insurance companies by employers in Workmen's Compensation premiums in 1943, the State Fund wrote \$31.3 million,^{8/} and private companies (61 stock companies and 24 mutual companies), \$84.3 million^{9/} (see Table 2). The 45,000 employers who insured with the State Fund at premium rates approximately 20 per cent lower than commercial rates saved more than \$6 million for the year,^{9/} despite the coverage by the State Fund of many poor risks not acceptable to private carriers. In 1944, some 500 employers and 700 political subdivisions were self-insurers.^{10/}

^{7/} Progress of State Insurance Funds under Workmen's Compensation, United States Department of Labor, Division of Labor Standards, Bulletin No. 30, 1939.

^{8/} Computed at standard rates set for insurance companies. Actual premium payments, because of lower rate schedules used by the State Fund, were \$25.1 million.

^{9/} New York State Insurance Report, 1944, Volume III, Table 9.

^{10/} Statement of Director of the Division of Self-Insurance, New York State Department of Labor, June 1945.

All four types of coverage are on a merit rating basis, which encourages accident prevention and, also, payment of as few claims as possible. Probably as a result of the financial incentive, there have been frequent instances of illegal pressure on physicians, insurance companies, and Workmen's Compensation Division employees to minimize claims and thus reduce employer costs.

The idea of the State engaging in the insurance business through the State Fund has been criticized as tending toward socialism. Yet, "after a quarter of a century of experience, it cannot be said that the 18 States that have adopted State compensation insurance funds, or all of the 9 Canadian Provinces with similar provisions, have gone farther in the direction of socializing all industry than have the remaining States".^{7/}

Insurance rates. Under Article 8 of the State Insurance Law, licenses are issued by the Superintendent of Insurance to rating organizations, which are established to set up rates on insurance risks, subject to approval of the State Superintendent of Insurance. There exists only one such organization at the present time, the Compensation Insurance Rating Board. Rate schedules may not be excessive, unreasonable, or discriminatory. Persons affected by the rate may have an opportunity to be heard. Upon payment of a fee, insurance companies may obtain rate schedules from these rating organizations for their own use in writing insurance. Rates charged by an insurer must be standardized according to the type of risk involved. There may be no rebates, discounts, etc. However, an insurance company may distribute dividends to policyholders from surplus or unearned premiums.

The State Insurance Fund is not bound by the rates set up for the commercial insurance companies. Its rates, although partially based on those of the Compensation Insurance Rating Board, are generally fixed at a somewhat lower level, reflecting the accident experience of the employer.

Comments. Tables 2 and 3 present data on premiums paid by employers for Workmen's Compensation insurance, and disposition of the premium funds.

Payments to injured workers per premium dollar paid by employers in New York State varied in 1943 from \$.584 per premium dollar paid to workers by the stock companies and \$.591 by mutual companies to \$.788 paid by the State Fund.^{11/} Private insurance companies base arguments for their higher premium rates on high taxes from which the State Fund is exempted. It has been contended by Thomas G. Gorman, Business Acquisition Director of the Fund,^{12/} that compensation insurance is in effect a tax on business, and that there is no economic defense of a system which permits farming out the collection of a tax to insurance companies operating for profit. Further, Federal and State taxes and fees (excluding Federal income tax) comprised only

^{11/} See Table 1. Based on experience in New York State. This excludes the unknown proportion of premiums paid back as dividends to the employer.

^{12/} Rochester, New York, Democrat and Chronicle, February 16, 1945.

\$.034 of each premium dollar for stock companies, \$.024 for mutual companies and \$.006 for the State Fund,^{13/} which tax rate does not justify the disparity in premiums. The State Fund pays rent and is assessed as are private companies to cover costs of administration by the Workmen's Compensation Board and the Compensation Insurance Rating Board. The great difference in distribution of premium income is in expense, particularly in acquisition of contracts, the stock companies paying \$.148 per premium dollar toward acquisition, the mutual companies, \$.047, and the State Fund, \$.007.^{13/} High acquisition cost in a form of social insurance would not seem to be justified since "insurance is compulsory and no amount of sales effort can change the amount written - it can only decide who will write it." ^{14/}

Despite the higher premiums and lower claims payments by stock and mutual insurance companies, financial reports filed with the State Superintendent of Insurance^{2/} indicate that in many instances the writing of compensation insurance does not pay; it is offered as an accommodation to employers for whom the company carries other types of insurance, or to attract clients to whom more profitable types of insurance can later be sold. This would appear to indicate that the sale of compensation insurance through a multitude of private carriers is not economical.

In view of the lower premiums and higher benefit returns of the State Fund, it might appear odd that a large number of employers continue to insure through stock and mutual companies. This situation, which exists in all States having a competing State Fund may be explained in part as a result first, of the fact that the State Fund is expected to take what business comes to it, and let private companies pick off the good risks; second, that most employers have connections with insurance companies handling other types of insurance for them; and third, that there is frequently a person connected with the firm who is interested in having the insurance go to a particular insurance company.^{7/}

Table 2. Workmen's Compensation Insurance Premiums Received and Claims Paid in New York State, 194^{2/}

Type of insurer	Premiums earned	Claims payments	Loss ratio per cent	Residue
61 stock companies	\$45,934,531	\$26,854,966	58.4 ^{b/}	\$19,129,565 ^{b/}
24 mutual companies	38,253,530	22,607,836	59.1 ^{c/}	15,645,694 ^{c/}
State Insurance Fund				
At standard rates	31,318,981	19,793,596	63.2	11,525,385
At actual rates ^{a/}	25,117,823	19,793,596	78.8	5,324,227
Total at standard rates	\$115,557,042	\$69,256,398	59.9	\$46,300,644
Total at actual rates	109,355,834	69,256,398	63.3	40,099,486

^{a/} The State Insurance Fund premiums average considerably lower than the standard rate set by the Rating Board despite acceptance by the State Fund of types of risk not acceptable to commercial insurance companies. State Fund figures are shown on the basis of premiums which would be charged if standard rates were used, and as those actually charged.

^{b/} Stock companies may make a slight refund of premiums at the end of the premium year to larger insurers.

^{c/} Mutual companies may refund up to 20 per cent of premiums as a dividend, at end of premium year.

^{13/} See Table 2. Based on nation-wide experience.

^{14/} Medical Relations under Workmen's Compensation, Revised, Bureau of Medical Economics, American Medical Association, Chicago, 1935.

Table 3. Workmen's Compensation Loss and Expense Ratios as Per Cent of Premiums Paid ^{2/}

Premiums, expense and net gain	National experience Stock ^{a/} Mutual ^{a/} companies companies		New York State Insurance Fund ^{b/}
Premiums earned	100.0	100.0	100.0
Claims payments	59.0	57.4	78.8
Expense	35.6	22.4	17.9
Claims adjustment	7.8	7.3	9.0
Acquisition & field supervision	14.8	4.7	0.7
General administration	7.8	5.3	5.7
Inspection and bureau	1.8	2.7	1.9
Taxes and fees	3.4	2.4	0.6
Net gain			
Before Federal tax	5.4 ^{c/}	20.2 ^{d/}	3.3
After Federal tax	4.4 ^{c/}	19.4 ^{d/}	3.3

^{a/} Based on nation-wide underwriting.

Includes 64 stock companies and 24 mutual companies.

^{b/} Based on premiums actually charged.

^{c/} Stock companies may make a slight refund of premiums at end of premium year to larger accounts.

^{d/} Mutual companies may refund up to 20 per cent of premiums as a dividend at end of premium year.

Benefits. A compensable injury is an accidental injury arising out of or in the course of employment, and any resultant disease and infection, excluding injuries resulting from the intoxication of the injured person while on duty, or the willful intention of the injured.

The injured individual has complete freedom of choice of authorized physician, and a notice of this right must be posted in the place of employment. THE PHYSICIAN IS NOT TO BE SUBJECTED TO INTERFERENCE OR IN PROPER INFLUENCING IN HIS DIAGNOSIS AND TREATMENT OF THE CASE. The employer is responsible for the costs of medical, surgical, and other attendance for as long as the injury requires, and for any artificial members or supports needed.

THE CHAIRMAN OF THE COMPENSATION BOARD AUTHORIZES PHYSICIANS, MEDICAL BUREAUS, AND LABORATORIES TO PERFORM COMPENSATION SERVICES ON THE BASIS OF RECOMMENDATIONS ON INDIVIDUAL APPLICATIONS FROM A LOCAL MEDICAL PRACTICE COMMITTEE. AUTHORIZATION IS GIVEN FOR SPECIFIC TYPES OF SERVICES OR SPECIALTIES. IN METROPOLITAN COUNTIES, THIS COMMITTEE IS COMPOSED OF THREE LICENSED PHYSICIANS OF OUTSTANDING QUALIFICATIONS APPOINTED BY THE CHAIRMAN OF THE COMPENSATION BOARD. IN LESS POPULOUS COUNTIES, THIS COMMITTEE MAY BE APPOINTED BY THE COUNTY MEDICAL SOCIETY, BUT IF NO ACTION IS TAKEN BY THE MEDICAL SOCIETY, THE CHAIRMAN APPOINTS THE COMMITTEE. PHYSICIANS ON THESE MEDICAL PRACTICE COMMITTEES MAY NOT ACCEPT WORKMEN'S

COMPENSATION PRACTICE THE PHYSICIAN DESIRING APPROVAL SUBMITS A STATEMENT OF HIS QUALIFICATIONS TO PRACTICE, INCLUDING THOSE IN ANY SPECIALTY HE PRACTICES THE MEDICAL PRACTICE COMMITTEE MAKES ITS RECOMMENDATIONS ON GENERAL AND SPECIALIST PRACTICE ON THE BASIS OF THIS APPLICATION. A PHYSICIAN WHO HAS BEEN REFUSED AUTHORIZATION TO PRACTICE HAS THE RIGHT TO APPEAL TO THE MEDICAL APPEALS UNIT OF THE STATE INDUSTRIAL COUNCIL FOR A REVIEW OF HIS QUALIFICATIONS

Only authorized physicians may render care, except that emergency care may be rendered by any licensed physician a licensed physician on a hospital staff may care for hospital patients, and under active and personal supervision of an authorized physician care may be rendered by a registered nurse, registered physiotherapist, or other person trained in diagnosis and laboratory techniques, provided that adequate signed records of instructions for treatment and reports of the patient's condition and progress are made by the physician and are submitted to the CHAIRMAN OF THE COMPENSATION BOARD NO PERSON MAY SOLICIT BUSINESS FOR PERSONS AUTHORIZED TO GIVE CARE.

To be eligible for authorization by the CHAIRMAN OF THE COMPENSATION BOARD laboratories and medical bureaus participating in treatment and diagnosis must be qualified for certification by the State Commissioner of Health, or the New York City Board of Health. In no case may more than two such laboratories or bureaus be operated by the same physician. Authorized laboratories or bureaus must submit periodic reports on personnel and equipment, be subject to inspection, and pay an annual license fee of \$50 per bureau and \$10 per laboratory.

The results of investigations made by THE LOCAL MEDICAL PRACTICE COMMITTEES of charges against authorized physicians are reviewed BY THE MEDICAL APPEALS UNIT OF THE STATE INDUSTRIAL COUNCIL and submitted AS ADVISORY RECOMMENDATIONS TO THE CHAIRMAN OF THE COMPENSATION BOARD HE MAY MAKE INDEPENDENT INVESTIGATIONS TO THE SAME END.

Authorization may be rescinded on grounds of professional misconduct or incompetency, exceeding limits of professional competence, misstatement of qualifications, FAILURE TO SUBMIT ADEQUATE AND VALID REPORTS TO THE CHAIRMAN OF THE COMPENSATION BOARD, rendering service under the minimum fee.^{15/} soliciting business, REFUSAL TO ANSWER ANY LEGAL QUESTION REGARD-

^{15/} The fixing of a minimum fee schedule is to insure that the injured worker receives adequate medical care. Since physicians are not permitted to reduce their fees, the employer or insurance company would have less reason to influence the claimant's choice of physician.

ING CONDUCT UNDER THE AUTHORIZATION, payment or receipt of any refund or gratuity, or maintenance of inadequate equipment and personnel by medical bureaus and laboratories. THE EDUCATION LAW PROVIDES FOR REVOCATION OF LICENSE FOR FEE SPLITTING, ETC.

RATINGS for medical services are established by the CHAIRMAN OF THE COMPENSATION BOARD after consultation with the State Medical Society and other interested parties. Payment is usually made on a fee basis, but the employer or insurance company is permitted to contract for the services of physicians, medical bureaus and laboratories on a salary basis. However, the employee is not required to accept a salaried physician, being guaranteed free choice. No payment may be accepted from injured persons. A physician's claim is valid only if within 24 hours of first treatment he notifies the CHAIRMAN OF THE COMPENSATION BOARD and the employer.

If the insurance company or employer wishes to question the physician's bill, an impartial review before the medical practice committee or a professional arbitration committee may be held. For each such case a charge of 2 per cent of the award is made against each party. If the physician's bill is upheld, a penalty is imposed on the complainant. To determine the contested claims, the CHAIRMAN OF THE COMPENSATION BOARD employs physicians to examine the claimants. These physicians may have no financial relationship with the employer or insurance company, may not treat the injury or recommend a physician for treatment, but may recommend the type of treatment needed.

Comments. The only data available on the amount paid to doctors and hospitals for various types of services under the Workmen's Compensation Law are those furnished to the Commission by one of the largest companies writing compensation insurance. They cover the month of June, 1945. Table 4 shows that 69 per cent of medical payments were made to physicians and 31 per cent to hospitals.

Table 4. Percentage Distribution of Payments for Medical Services by Type of Service Rendered, June 1945

Service rendered	Payments for service		
	To doctors	To hospitals	Total
Office calls - no other service	25	1	26
Office calls with x ray; physiotherapy or minor operations	10	1	11
Operations including x ray, physiotherapy and after care	25	26	51
Physiotherapy alone	1	0	1
X rays, and x ray and physiotherapy alone	2	1	3
Special hospital charges	1	0	1
Drugs, supplies, transportation, etc.	5	2	7
Total	69	31	100

16/ ANY PERSON VIOLATING, ATTEMPTING, OR AIDING VIOLATION OF THIS REFUND CLAUSE IS GUILTY OF A MISDEMEANOR.

Freedom of choice of physician is a relatively new concept. Prior to 1935, the power of selection rested with the employer, except where he neglected to provide the necessary aid. After introduction of freedom of choice, penalties were provided in case of interference with the free selection of physician.

There is no direct financial relationship permitted between the patient and the physician, although ordinarily in other situations organized medicine insists that there be no agent between patient and physician to provide payment and regulate service.

Authorization of physicians to practice in Workmen's Compensation cases was, until recently, a function of the county medical societies. Their recommendations for approval and also for removal from the list were mandatory on the chief administrative officer, who was not free to make his own investigations of such professional matters. However, the county medical societies were found inadequate in both of these matters. Few actions were taken against physicians who were known to be guilty of gross abuses. As a corrective measure, this authority was allocated to medical practice committees (appointed by the Chairman of the Compensation Board) whose recommendations are advisory rather than mandatory on the administrative officer.

It was necessary to insist that care be given only by authorized physicians or under their active and personal supervision since many cases were discovered of care being given by unqualified personnel, without adequate supervision by the physician employing them.

Many instances were found where Workmen's Compensation practice took on the aspect of a racket, with middle-men obtaining patients for physicians, unnecessary treatments being ordered by physicians in order to obtain kickbacks; and fee splitting becoming an accepted practice of specialists. To prevent such situations from continuing, it was necessary to provide heavy penalties for malpractice of this type and to make compensation practice subject to direct investigation by the Chairman of the Compensation Board, rather than vest this power in the profession through non-official channels, or entirely with official representatives of the profession.

There has been a decided tendency to pad medical treatment and fees, presumably because payment is made on a fee-for-service basis.

The employment by the State of competent professional personnel, adequately reimbursed and furnished with necessary medical facilities is most important in obtaining an impartial diagnosis for use in adjudicating claims.

Appeals. Awards made by referees of the WORKMEN'S COMPENSATION BOARD as well as prior BOARD awards may be reviewed by the BOARD. Further appeals may be made to the courts. Fines are levied for unjustified appeals or those intended for the purpose of delay. WITHDRAWAL OF AN APPEAL COSTS \$50.

Persons other than attorneys appearing for claimants or for self-insurers must be licensed. Legal fees charged injured persons must be approved by the BOARD. No person may solicit employment for a lawyer in compensation cases.

The CHAIRMAN OF THE COMPENSATION BOARD has the right of recourse for compensation against any employer or insurance company in the name of an

injured worker.

Comments. Appeals by employers and insurance companies are frequently taken for the purpose of delay and bargaining. Between 1940 and 1942 inclusive, 70 per cent of all appeals were subsequently withdrawn, presumably because ill-founded. The State Fund has been a serious offender, withdrawing 93 per cent of its considerable number of appeals in the three year period^{5/}. Thus the State Fund seems to have taken hundreds of appeals with no serious intention of carrying them through.

To make proper and necessary legal advice available to all claimants, the services of a panel of legal advisers might be made available free of charge.

Administration. ADMINISTRATIVE AUTHORITY IS NOW CENTRALIZED IN A FULL-TIME WORKMEN'S COMPENSATION BOARD IN THE DEPARTMENT OF LABOR. THE BOARD CONSISTS OF TEN MEMBERS APPOINTED BY THE GOVERNOR, OF WHOM AT LEAST THREE MUST BE PRACTICING LAWYERS. ALL EXECUTIVE AND ADMINISTRATIVE AUTHORITY IS VESTED IN THE BOARD MEMBER WHO IS DESIGNATED BY THE GOVERNOR AS CHAIRMAN.

THE BOARD, EXCLUDING THE CHAIRMAN, IS DIVIDED INTO THREE PANELS, WITH A LAWYER ON EACH PANEL. ALL HEARINGS ARE CONDUCTED BY THESE PANELS. THE BOARD HEARING SCHEDULE MUST BE KEPT UP TO DATE. WHENEVER CASES ARE PENDING FOR MORE THAN 30 DAYS, THE PANELS MUST HOLD HEARINGS AND DISCHARGE THEIR DUTIES EVENINGS AND ALL DAYS OF THE WEEK EXCEPT SUNDAY, IN ADDITION TO THEIR REGULAR WORK HOURS.

THE CHAIRMAN OF THE WORKMEN'S COMPENSATION BOARD HAS AT HIS DISPOSAL FUNDS TO FINANCE STUDIES ON ADMINISTRATION, ETC. WITH A VIEW TO IMPROVING NEW YORK STATE WORKMEN'S COMPENSATION LEGISLATION AND ADMINISTRATION.

In addition there is an advisory body known as the State Industrial Council. IT IS COMPOSED OF THE INDUSTRIAL COMMISSIONER, THE CHAIRMAN OF THE WORKMEN'S COMPENSATION BOARD, THE CHAIRMAN OF THE BOARD OF STANDARDS AND APPEALS, AND NINE OTHER MEMBERS REPRESENTING EMPLOYERS, EMPLOYEES, AND PHYSICIANS. THE COUNCIL ACTS ONLY IN AN ADVISORY CAPACITY ON WORKMEN'S COMPENSATION. THE PHYSICIANS ON THE COUNCIL CONSTITUTE A MEDICAL APPEALS UNIT TO REVIEW THE WORK OF MEDICAL PRACTICE COMMITTEES AND TO PRESCRIBE RULES GOVERNING THEIR OPERATIONS.

The Industrial Commissioner is head of the State Insurance Fund. The CHAIRMAN OF THE COMPENSATION BOARD is head of the Division of Self-Insurance.

All administrative costs are met by assessments against employers who insure themselves, insurance companies, and the State Fund.

Comments. Several changes in the administrative pattern of Workmen's Compensation have been effected within the last few years in an attempt to prevent recurrence of abuses and maladministration such as were revealed by recent investigations. The 1945 Legislature established a full time Workmen's Compensation Board to replace the Industrial Board which was headed by the Industrial Commissioner. Apparently, centralization of administration in the new board and its chairman, who are to be responsible solely for this function on a full-time basis, was deemed more efficient and effective than prior experiments with part time boards and an executive who was responsible for many programs rather than just one.

The panel system of hearing appeals and claims, with a lawyer at the head and the provision of the law requiring prompt processing of claims - particularly those pending over 30 days - meet long felt needs, since previously claims were heard by boards which were not always cognizant of the legal implications of the cases, and claims hearings and appeals could be delayed indefinitely, even for years.

Summary. Workmen's Compensation has made tremendous and admirable strides since it was first introduced three decades ago. Without doubt, it has afforded a greater degree of protection to the worker than could have been obtained without compulsory State legislation. However, even greater protection might have been afforded if poor administration had not frequently lessened the benefits which were due the worker. High employer premiums have not sufficed to provide the good medical service and prompt cash payments that are expected. The shortcomings of the system seem to be attributable to specific administrative faults, rather than a fundamental defect in the principle of insurance. Although many steps have already been taken to combat the difficulties, some of the faults are inherent in the structure of the New York State system and cannot be eliminated without further, radical reorganization.

Recent trends in Workmen's Compensation legislation show an increasing realization of the need for adequate professional direction and vision in this program by public spirited, competent professional persons who are interested in the program and in the need for adequate administration. Insurance of this nature is not a business venture, the success of which is to be measured only in economies; it has the broad social objective of restoring and rehabilitating workers to the greatest degree possible, so that their earning power may be sustained.

An approach to the realization of this need has been made in the designation of administrators whose sole duty is the execution of the program, rather than part time administrative personnel whose interests are divided, and the allocation of responsibility for professional matters to professional persons in official capacities, rather than to non-official

professional organizations which have not adequately exercised their functions.

The method of insuring through private companies, which have an interest in maintaining high premiums while minimizing claims payments, may be another fault. Insurance companies often lack understanding of the social aspects of Workmen's Compensation and fail to cooperate in the aim of providing adequate compensation to the sick or injured worker. The State Fund as well, seems to have lacked understanding of its proper function in insuring employees.

The problems of private versus public compulsory medical insurance are well illustrated in this program. The advantages of private insurance seem to be:

1. It retains private enterprise in a field which until recently has been reserved for private enterprise.

2. Flagrant abuses may be prevented by close government regulation.

The disadvantages of private insurance seem to be:

1. It results in a virtual farming out of the collection of a tax to private insurance companies.

2. Enforcement of complete coverage is impractical. Some four million employees are protected by Workmen's Compensation legislation; however, because of varied methods of obtaining insurance and the multiplicity of private insurance companies active in the field, it is impossible to determine accurately the extent of compliance with the law.

3. There are many poor risks not acceptable to private companies. A State agency is necessary to cover these; if such a public agency must be created, it might well cover all insurance.

4. Private companies require excessive premiums, or modify claims payments and the acceptability of risks in order to meet high acquisition costs and to show a profit, thus invalidating to some extent the objectives of the program.

5. One large insurer, such as a State Fund, is better equipped to carry out public educational programs than are a number of small insurers. The educational function of the insurance agent in accident prevention has been carried out in some excellent programs of private companies, but is not practicable for most of the 85 private insurance companies because of the relatively small number of policies carried in any one area. The State Fund has been able to afford a large safety service department to provide engineering and inspection service and to advise on improvements

of physical conditions.^{17/}

6. Where an exclusive State Fund exists, it is possible to effect great economies of operation since accidents are reported to only one agency, only one investigation is necessary, and payments are made through only one agency, with no need for a check-up by a State supervisory agency. This is borne out by the comparative experience of exclusive and competing State Funds. In Ohio, where there is an exclusive State Fund, administrative expenses (exclusive of accident prevention) between 1940 and 1943 are reported to have ranged from 5.90 to 3.96 per cent.^{17/} This includes all costs of administering the program. The New York State Fund, a competing insurance company, had administrative costs ranging from 17.6 per cent to 18.8 per cent in this period;^{9/} this includes only that part of the State Workmen's Compensation Division costs which were allocated to the Fund.

The idea of an exclusive fund is not particularly socialistic. Such funds exist in several States. It has a counterpart in other types of social insurance, such as Unemployment Insurance and Old Age and Survivors Insurance. Experience seems to indicate that once a system of compulsory insurance through competing private companies is incorporated, the later establishment of an exclusive fund is not feasible.

Abuses by patients, physicians, laboratories, etc. are inevitable under any such broad medical program as Workmen's Compensation. Fee splitting and excessive treatment may tend to increase where payment is made on a fee for service basis. There is also a tendency towards malingering because cash benefits usually depend on continued medical care as proof of incapacity to work. Comprehensive administrative controls are imperative to minimize such abuses, which may discredit or undermine the financial structure of the program.

Although physicians frequently protest any suggestion of interference in the physician-patient relationship, as obtains to some extent under the Workmen's Compensation Law, the freedom of physicians to diagnose and treat cases without interference, the provision of adequate fees, and the utilization of the organized medical profession in an advisory capacity seems to have overcome many of the traditional objections to government participation.

Miscellaneous Programs

In addition to the programs described, small amounts are expended

^{17/} Letter from Walter E. Taylor, Assistant Actuary, Workmen's Compensation, Industrial Commission of Ohio.

by local health departments and other public agencies for certain medical services. These are often in the form of subsidies to private agencies such as hospitals, clinics and visiting nurse associations. Few data have been collected on this subject and it is impossible to do more than indicate the nature and amount of these expenditures. In addition to receiving fees-for-service, visiting nurse associations are sometimes granted small subsidies by municipalities. In 1942, ten local health departments expended \$190,000 for hospitalization of cases of communicable disease. 20 full-time and 745 part-time local health officers outside of New York City provide, usually at no cost in addition to their regular salaries,^{18/} immunization against diphtheria and small-pox, and a few miscellaneous services. In addition, they may be paid extra sums by the locality for the treatment of venereal disease. For the entire State, the annual cost or value of services of this type, i.e., of a type ordinarily purchased individually, may amount to \$200,000 or more. A figure roughly estimated at \$0.5 million would probably cover all of the miscellaneous programs.

^{18/} \$0.15 per capita in districts of 8,000 population or less; for larger districts, salary in excess of \$1200 is by arrangement.

CHAPTER IX

THE COST OF MEDICAL CARE

In other chapters of this report detailed data are furnished on the volume and cost of medical care provided through public programs and through organized private insurance and prepayment programs. The cost of medical care obtained privately has been estimated in Chapter IV by subtracting the cost of public medical care programs from the total income received by all physicians, dentists, hospitals, etc. This chapter deals primarily with estimates of the total cost of service rendered. Data on the volume of service needed or provided are presented and discussed in Chapters XIII and XIV.

Physicians' Services

The year 1941 was selected because at that time a majority of the State's physicians were still engaged in civilian practice. A sample of approximately 25 per cent of physicians was obtained by taking every fourth name in the Medical Directory of New York^{1/} which lists, as of May 1, 1941, all physicians who have registered with the various county clerks (as required by law) their licenses to practice medicine in this State. The Directory list includes very few interns, residents, retired or other inactive physicians, and physicians engaged in full time administrative, teaching and research positions. The sample was turned over to the New York State Department of Taxation and Finance, whose regular employees matched the names of physicians in the sample with 1941 State income tax returns, and recorded the data for salary income from the practice of medicine and gross income from the private practice of medicine. Other types or sources of income were not included. The whole procedure was conducted with the utmost respect for the confidential nature of the income tax returns, and the data furnished to the Commission were only for 5 large geographic districts^{2/} so that an indi

1/ Medical Directory of New York, New Jersey and Connecticut, 1941 1942, Medical Society of the State of New York.

2/ New York District: Bronx, New York, Dutchess, Kings, Nassau, Orange Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster and Westchester counties. Albany District: Albany, Clinton, Columbia, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties. Syracuse District: Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, St. Lawrence, Tioga, and Tompkins counties. Rochester District: Allegany, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming and Yates counties. Buffalo District: Cattaraugus, Chautauqua, Erie and Niagara counties.

vidual physician could in no way be identified. Data relating to the sample are shown in Table 1. Among the reasons for failure to find an

Table 1. Total Physicians, Number in Sample and Percentage for Whom Income Tax Returns Were Found, New York State, 1941

District	In Directory	Sample		
		Number	Returns found	
			Number	Per cent
New York	19,505	4,817	3,733	77.5
Albany	1,365	338	278	82.2
Syracuse	1,862	461	375	81.3
Rochester	1,356	336	293	87.2
Buffalo	1,632	404	315	78.0
State	25,720 ^{a/}	6,356	4,994	78.6

a/ Varies slightly from total of 25,780 given in Directory.

income tax return there were the following: removed from State, resident of another State, in armed forces by April 1942 and not required to file return until completion of service, net income from salary less than \$1500 if single or \$2500 if married, gross

income from business less than \$5000, address incomplete, etc.

Payments received by physicians as reported in the tax returns are shown in Table 2. Gross income averaged about \$7,380 in 1941, of which

Table 2. Amount and Source of Gross Income from Practice of Medicine by 4,994 Physicians New York State, 1941

District	Professional income			
	Amount		Source (per cent)	
	Total	Average	Salary	Practice
New York	\$27,030,025	\$7,241	15.4	84.6
Albany	2,204,042	7,928	11.6	88.4
Syracuse	2,766,751	7,378	15.2	84.8
Rochester	2,376,488	8,111	12.0	88.0
Buffalo	2,488,385	7,900	13.9	86.1
State	36,865,691	7,382	14.9	85.1

15 per cent was received as salary for full or part time work. This amount may be compared with an estimate of \$8,044 for New York State physicians in 1941, calculated from data from another source.^{3/}

In translating these figures into total payments to physicians, the State average of \$7,382 may be multiplied by 25,720 to yield a figure of \$190 million on the assumption that the physicians for whom returns were not found correspond to those for whom returns were found.^{4/} On the other hand, it seems more likely that the average income of those for

^{3/} "Incomes in Selected Professions, Part 4. Medical Service," E. F. Denison and Alvin Slater, Survey of Current Business, 23:16, Oct. 1943. 452 New York State physicians were sampled. Average net income was \$4,746, which, adjusted to gross on basis of national figures showing net income to be 59 per cent of gross income, yielded an estimated gross income of \$8,044. The figures were New York City: net \$4,701, gross \$7,975; rest of State: net \$4,878, gross \$8,260.

^{4/} In a study of physicians for whom returns could not be found at the Directory address and for whom subsequent addresses were obtained from telephone and city directories, the average income was \$8,024.

whom returns were not found was lower than for those for whom returns were found, and it would seem proper to assign a gross income of about one-half of the average, i.e., \$3,690 to those for whom returns were not found. On this basis, total income payments would be \$170 million, as shown in Table 3. This figure, which is about 17 per cent of payments to physicians in the entire United States in 1941^{5/} (New York State had about 10 per cent of the nation's population), seems reasonably accurate, and is more likely to be an underestimate than an overestimate. Estimated

Table 3. Estimated Payments for Physicians' Services,
New York State, 1941

District	Average per physician	Total (millions)	Per capita	
			Actual	Adjusted ^{a/}
New York	\$6,442	\$125.6	\$13.49	\$12.18 ^{a/}
Albany	7,176	9.8	10.43	10.43
Syracuse	6,690	12.5	9.32	9.32
Rochester	7,545	10.2	10.82	10.82
Buffalo	6,972	11.4	9.31	9.31
State	6,591	169.5	12.32	11.49 ^{a/}

^{a/} Because New York City serves as a center for a large number of non-residents, these figures were adjusted by adding one million to the resident population figures.

average per capita payments for physician's services are also shown in Table 3. The adjusted figures indicate a range of from \$9.31 to \$12.18, the figure for the whole State being \$11.49.

Inasmuch as the public medical care cost data which are employed in this report relate to 1944 and 1945, it has seemed desirable to estimate from the figures shown herein, the payments made in the period around 1944. The only available data^{5/} indicate a 10 per cent increase nationally from 1941 to 1942. Owing to the large number of physicians who were in the armed forces in 1944, it does not seem likely that total payments to physicians have kept pace with the 45 per cent increase in total income payments in New York State from 1941 to 1944 (a 64 per cent increase in wage and salary payments, and a 29 per cent increase in other income payments)^{6/}, but it would seem reasonable to assume an increase of 30 per cent, to yield a working figure of \$220 million for 1944.

Dentists' Services

Data on payments to dentists were collected in the same fashion as for physicians, except that the Directory issued by the State Department of Education was employed. Data relating to the sample are shown in Table 4. The payments to dentists are shown in Table 5. Gross income averaged about \$7,300, of which 6 per cent was received as salary for

^{5/} "Consumption Expenditures, 1929-43," W. H. Shaw, Survey of Current Business, June 1944.

^{6/} Survey of Current Business, August 1945.

Table 4. Total Dentists, Number in Sample, and Per Cent for Whom Income Tax Returns were Found, New York State, 1941

District	In Directory	Sample		
		Number	Returns found	
			Number	Per cent
New York	8,549	2,115	1,641	77.6
Albany	448	112	89	79.5
Syracuse	604	149	119	79.9
Rochester	534	135	100	74.1
Buffalo	704	174	139	79.9
State	10,839	2,685	2,088	77.8

Table 5. Amount and Source of Gross Income from Practice of Dentistry by 2,088 Dentists, New York State, 1941

District	Professional income			
	Amount		Source (per cent)	
	Total	Average	Salary	Practice
New York	\$12,099,379	\$7,373	6.1	93.9
Albany	580,919	6,527	7.7	92.3
Syracuse	934,962	7,857	4.2	95.8
Rochester	696,598	6,966	5.8	94.2
Buffalo	926,896	6,668	2.5	97.5
State	15,238,754	7,298	5.8	94.2

Table 6. Estimated Payments for Dentists' Services, New York State, 1941

District	Average per dentist	Total (millions)	Per capita	
			Actual	Adjusted ^{a/}
New York	\$6,539	\$55.9	\$6.00	\$5.42 ^{a/}
Albany	5,936	2.6	2.83	2.83
Syracuse	7,010	4.2	3.17	3.17
Rochester	6,106	3.3	3.45	3.45
Buffalo	6,061	4.3	3.49	3.49
State	6,487	70.3	5.11	4.76 ^{a/}

^{a/} Because New York City serves as a center for a large number of non-residents, these figures were adjusted by adding one million to the resident population figure.

full or part-time work. In translating these figures into total payments to dentists, multiplication of the State average of \$7,298 by 10,839 yields a figure of \$79 million, on the assumption that dentists for whom returns were not found correspond to those for whom returns were found.^{7/} If, as in the case of physicians, a gross income of one-half of the average, i.e., \$3,650 is assigned to those for whom returns were not found, the annual total payments amount to \$70 million (see Table 6). This figure is about 15 per cent of payments to dentists in the entire United States in 1941.^{5/}

The estimated average per capita payments for dentists' services range from \$2.83 to \$5.42, the average being \$4.76. Adjusting total payments to dentists on the same basis as was employed for physicians yields an estimate of \$90 million for 1944.

^{7/} In a study of dentists for whom returns could not be found at the Directory address and for whom other addresses were obtained from telephone and city directories, the average income was \$6,856.

Nursing Service

Because of its association with (and often, inclusion in) hospital service, and because income tax data for nurses do not lend themselves readily to analysis, a cost study of nursing service in New York State was not undertaken, except for visiting nurse service. National expenditures for private duty trained nurses, and for practical nurses and midwives are shown in Table 7. It would seem reasonable to assume that New York State expenditures would be about 15 per cent of the national

Table 7. National Consumption
Expenditures for Nursing Service
Not Included in Hospital Service
Costs^{2/} (in Millions)

Year	Private duty trained nurses	Practical nurses and mid- wives
1929	\$113.0	\$86.0
1930	104.2	74.0
1931	87.7	56.0
1932	67.3	41.0
1933	59.3	34.0
1934	62.8	39.0
1935	64.3	40.0
1936	68.2	46.0
1937	66.9	52.0
1938	61.1	43.0
1939	59.2	45.0
1940	57.9	48.0
1941	58.2	51.0
1942	59.3	61.0

total, as is true in the case of physicians, dentists, and hospitals. On this basis, it may be assumed that in a year such as 1944, about \$11 million would be spent for the services of private duty trained nurses, and about \$12 million for the services of practical nurses. These amounts do not include payments to nurses employed by visiting nurse associations, schools, health departments or hospitals.

Hospital Service

The most recent data available which were suitable for analysis were 1943 occupancy data and 1942

cost data. These are presented in Table 8 for the general hospitals of the State, i.e., all hospitals except Federal hospitals, mental and tuberculosis hospitals, and departments of institutions (county homes, penitentiaries, etc.). The total cost for general hospital care in 1942-43 was \$125.6 million, or \$9.13 per capita. To obtain a comparable estimate for 1944, an upward adjustment of about 15 per cent is indicated on the basis of a 10 per cent increase in payments from 1942 to 1943^{5/} and from increases in per diem costs reported by various individual hospitals. It is thus estimated that payments for general hospital service would be about \$144 million in 1944.

The cost of care in private tuberculosis hospitals is similarly estimated to have been \$2,162,000 in 1942-43, and \$2.5 million in 1944. The cost of care in private mental hospitals is not known, but is roughly estimated at \$3 million.^{8/}

^{8/} Average census of 1600 patients at \$5 per day.

Table 8. Cost of General Hospital Care, New York State, 1942 43

Type of hospital	Days care ^{a/}	Average daily rate ^{b/}	Total payments
General			
Public	5,106,350	\$5.69	\$ 29,055,131
Private	10,612,375	7.89	83,731,639
Orthopedic			
Public	44,165	4.45	196,534
Private	394,200	6.28	2,475,576
Contagious			
Public	250,755	5.96	1,495,425
Other special			
Public	137,970	2.74	378,038
Private	1,408,570	5.89	8,296,477
All types			
Public	5,539,240	5.62	31,125,128
Private	12,415,145	7.61	94,503,692
Total	17,954,385	7.00	125,628,820

a/ From Hospital Number, Journal of American Medical Association, March 25, 1944. Covers care of adults only.

b/ From data in Social Welfare in 1943, 77th Annual Report, N. Y. State Department of Social Welfare. Rates for "general" and "other special" hospitals have been adjusted to cover care for infants born therein, for an average period of 10 days at a cost one-fourth of that for adults.

Other Services

The cost of clinic service is almost entirely included in general and special hospital service, except for health department clinic services, which have been shown separately. Data were not obtained on the services of osteopathic physicians or optometrists.

CHAPTER X

PRIVATE MEDICAL AND HOSPITALIZATION INSURANCE

In addition to the non-profit medical and hospitalization insurance described in subsequent chapters, many New York State residents are covered by insurance purchased privately. Nearly all of this insurance is held by employed persons and, in many instances, the employer bears all or part of the expense.

Group Health and Accident Policies

At the request of the Commission, Mr. Albert Pike, Jr., of the Life Insurance Association of America, undertook to ascertain the extent of coverage of New York State residents by group health and accident policies. All of the major companies writing this type of insurance in New York State were circularized. The figures given below are from reports by 11 life insurance and 8 accident and health insurance companies which represent more than 90 per cent of the entire private group health and accident business done in New York State. A characteristic common to all of these plans is that they pay a stipulated sum to the individual rather than to the physician or hospital, as is the case in non-profit and self-insuring organizations.

Hospital expense. This type of policy pays a stipulated amount for each day's hospital confinement and, in some cases, an extra allowance is made for operating room charges, etc. Hospitalization for maternity cases is allowed in about 80 per cent of contracts. The 1944 premium income from this type of policy was \$4,601,525. Coverage was afforded to 375,211 employees, and an estimated 300,923 dependents,^{1/} a total of 676,134 persons. The amount designated as "daily benefits" for employees was \$1,739,982 or \$4.64 per person per year, and for dependents, \$581,652 or \$1.93 per person per year. Being lower than for the non-profit plans,^{2/} these figures signify fewer benefits or services, especially for dependents.

Surgical expense. This type of policy pays a stipulated amount for specified surgical procedures undergone by the participant. The 1944 prem-

^{1/} Number of dependent certificates multiplied by 2.5, as average number of dependents per family or certificate. The number 2.5 corresponds quite closely to the number of dependents per family contract under non-profit medical and hospitalization insurance.

^{2/} Median hospital expense per one-person contract, Blue Cross 1944, was \$5.68. Median hospital expense per participant under family contracts was \$3.68. Experience of Blue Cross Hospital Service Plans, Hospital Service Plan Commission, American Hospital Association, Chicago, 1944.

ium income was \$2,462,510. Coverage was afforded to 378,857 employees and an estimated 74,288 dependents,^{1/} a total of 453,145 persons. The usual policy of this type has a maximum that will be paid per person per year or per surgical procedure. The maximum amount payable for employees amounted to \$51,797,613 or an average of \$136.72 per person per year, and for dependents \$3,099,075 or \$41.72 per person per year.^{2/}

Medical expense. This type of policy pays a stipulated amount for certain types of illness; it often applies only to hospitalized illnesses. The 1944 premium income was \$4,521. Coverage was afforded to 1,127 employees. No dependents were covered. The amount designated as "daily benefits" was \$4,883 or \$4.33 per person per year.^{4/}

Cash sickness benefits. The study also included policies paying weekly benefits for specified illnesses. The 1944 premium income of \$12,587,709 covered 707,407 employees. The amount designated as "weekly benefits" was \$12,480,945 or \$17.79 per person per year.

Individual Policies

Little is known concerning policies purchased individually rather than in groups. It is probable that a very large number are of the familiar type paying a stipulated amount in the event of accidental injury. Although detailed data are not available, it is estimated that policies covering hospital benefits only, somewhat similar to Blue Cross and private group policies, numbered about 3,400 at the end of 1941.

Comparison of Private and Non Profit Policies

It is difficult to generalize concerning policies issued by private companies, because more than 800 different types are issued in the general field of health and accident insurance. It is probable that the private companies grade premiums more nearly according to individual risk than do the non-profit corporations. The different approaches to the coverage of large groups is illustrated by the experience in Rhode Island when bids were solicited from the local Blue Cross plan, and from 7 private insurance companies, for coverage of the entire population of Rhode Island for hospital service. Under the arrangement proposed, premium payment would be on a compulsory basis, with the service to be purchased

^{3/} On the assumption that about one half of premium income would be used for payment of benefits, the amount paid out per capita would be \$2.72, as compared with a range of \$2.91 to \$3.88 for the non-profit plans in New York State.

^{4/} Assuming again that about one half of premium income would be used for payment of benefits, the amount per capita would be \$2.19. No basis for comparison is afforded since the only figure for medical expense for single persons is \$5.85 in the Western New York Plan, which covers medical services both in and out of hospital.

by the State from non-official insurance agencies.^{5/}

The Blue Cross plan submitted the following proposal:

Every employee as defined in the Rhode Island Unemployment Compensation Act would be covered, and such employees might voluntarily enroll spouse and unmarried children under age 19. Upon leaving employment, voluntary insurance for self and dependents might be continued by direct premium payments. Benefits would consist of bed, board, and general nursing care at the hospital's rate up to maximum of \$5.50 per day **and**, without cost to patient, the following extra services: operating and delivery room, ordinary medicines and surgical dressings, laboratory examinations, basal metabolism tests, oxygen and serums, physical therapy, electrocardiogram, x-rays except x-ray therapy and radium. Limitations would be: care only in a hospital specifically approved; not more than 45 days in any one admission; mental and tuberculous cases for first admissions only. The annual rates would be: \$10.20 for employee only, and an additional charge of \$13.20 for voluntary insurance for spouse and unmarried children under 19, a total of \$23.40 for family coverage.

Only 4 of the 7 private companies submitted rates, which are summarized as follows:

Employee coverage should be limited at the outset to groups of 10 or more employees, with employee permitted to enroll spouse and unmarried children between 3 months and 18 years of age on a voluntary basis only if 75 per cent of those at each place of employment with eligible dependents would agree to do so. Insurance would not be continued on a direct payment basis upon termination of employment; instead, extended coverage for a short period without payment of premiums would be offered. Employers would be permitted to act as self-insurers. The benefits and limitations would be as in Blue Cross plan, except that a maximum dollar value would be placed on extra services, including operating room, medicines, etc. The annual rates for employees and for dependents would be as shown in Table 1.

Table 1. Annual Premiums for Group Hospital Service
as Proposed by Four Private Insurance Companies,
Rhode Island, 1945.

Firm	Employees only			Additional charge for dependents
	Less than 11 p.c. females	50 p.c. females	More than 91 p.c. females	
1	\$9.12	\$13.68	\$19.44	\$30.24
2	9.60 ^{a/}	13.92	18.72 ^{b/}	31.80
3	10.80 ^{c/}	13.44	18.96	30.48 ^{f/}
4 ^{d/}	12.00	14.40	18.00	26.76 ^{f/}
4 ^{e/}	9.72	13.08	17.64	26.76 ^{f/}

a/ Less than 25 per cent females.

b/ More than 75 per cent females.

c/ Less than 33 per cent females.

d/ Firms of 10-50 employees.

e/ Firms of over 50 employees.

f/ Minimum rate.

Note: Above rates would be increased from 15 to 40 per cent in industries such as railroads, breweries, furriers, hot metal industries, refineries, liquor and wine wholesalers, and in any industry where there is an abnormal proportion of higher-age persons.

^{5/} From Report of the Technical Committee to the Rhode Island Voluntary Advisory Council of Health, February 19, 1945.

CHAPTER XI

NON-PROFIT HOSPITAL SERVICE PLANS

History and Development

The cost of hospitalization amounts on the average to only 12 or 13 per cent of the private consumer's total annual expenditure for all types of medical care. For the individual or family, however, the cost is largely unpredictable as to time and amount, it is often accompanied by loss of earnings and it involves additional expenditures of approximately an equal amount for professional care. The assurance that at least a part of these unusual costs can be met from one's own resources at the time when they arise has been sought by millions of people in recent years.

The idea of sickness insurance on the basis of cash payments to the patient for specified illnesses, as offered by commercial and fraternal organizations, is not new, but it is only within the past ten years that insurance against the cost of hospital care has been offered by non-profit organizations on a service basis (i.e., with all costs paid for) to the community at large. The movement for such non-profit hospitalization plans originated when

In 1929 a group of teachers in Texas were faced with the fact that as individuals they could not save enough to pay hospital bills in an emergency. Millions of other Americans had found themselves in the same plight without doing anything about it. But these Texas teachers did something about it. By a little figuring, they found that as a group they could easily pay all the hospital bills they were likely to incur. So they persuaded the Baylor University Hospital at Dallas, Texas, to agree, for \$3 each school semester, to provide 21 days of hospital care to any one of them who needed such care. When the experiment proved successful, others besides school teachers asked to be included in the plan. Other hospitals learned about it and followed suit. But in cities having more than one hospital, overlapping and competition difficulties arose. It became clear that to be really successful, any plan would have to include nearly all the hospitals in the area and permit the patient to choose the one he wished. This was the beginning of Blue Cross.^{1/}

In 1933, the American Hospital Association Board of Trustees approved the principle of hospitalization insurance and set up general standards for acceptable plans. In 1936, the Julius Rosenwald Fund made a grant to the Association for the establishment of a Commission on Hospital Service, which provides information and advice to hospitals or communities contemplating the establishment of hospitalization insurance plans, serves as a clearing house of information for the executives of existing plans,

^{1/} The Story of Blue Cross, L. H. Pink, Public Affairs Pamphlet 101, 1945.

studies related problems of hospital administration and finance, and approves new hospitalization insurance plans wishing to use the name "Blue Cross", which signifies such approval. Most of the national professional associations have directly or indirectly approved the principle of insurance for the payment of hospital bills. First among them was the American College of Surgeons which voted approval in 1934. The American Medical Association, which at first opposed voluntary hospitalization insurance, in 1937 established a set of principles which should characterize such insurance if it were to develop throughout the United States. In 1938 it formally approved the principle of hospital service insurance, emphasizing that it was capable of great expansion along sound lines, but stating that such plans should confine themselves to providing hospital facilities and should not include any type of medical care.^{2/3/}

In this State, hospitalization insurance was first tried out in New York City in 1935. Within the next few years eight other plans were organized to cover the remainder of the State. The areas they cover are shown in Figure 1. Although some industrial plans and some private insurance policies include hospitalization costs as a benefit or indemnity, it is estimated that they cover no more than 800,000 persons or about 6 per cent of the population of New York State. The benefits of such policies usually provide only a stated amount for each day of hospitalization, and do not meet the full cost of the hospital service. Today, the Blue Cross plans, which cover 3 million persons, 23 per cent of the State's population, provide the great bulk of hospitalization insurance in New York State.

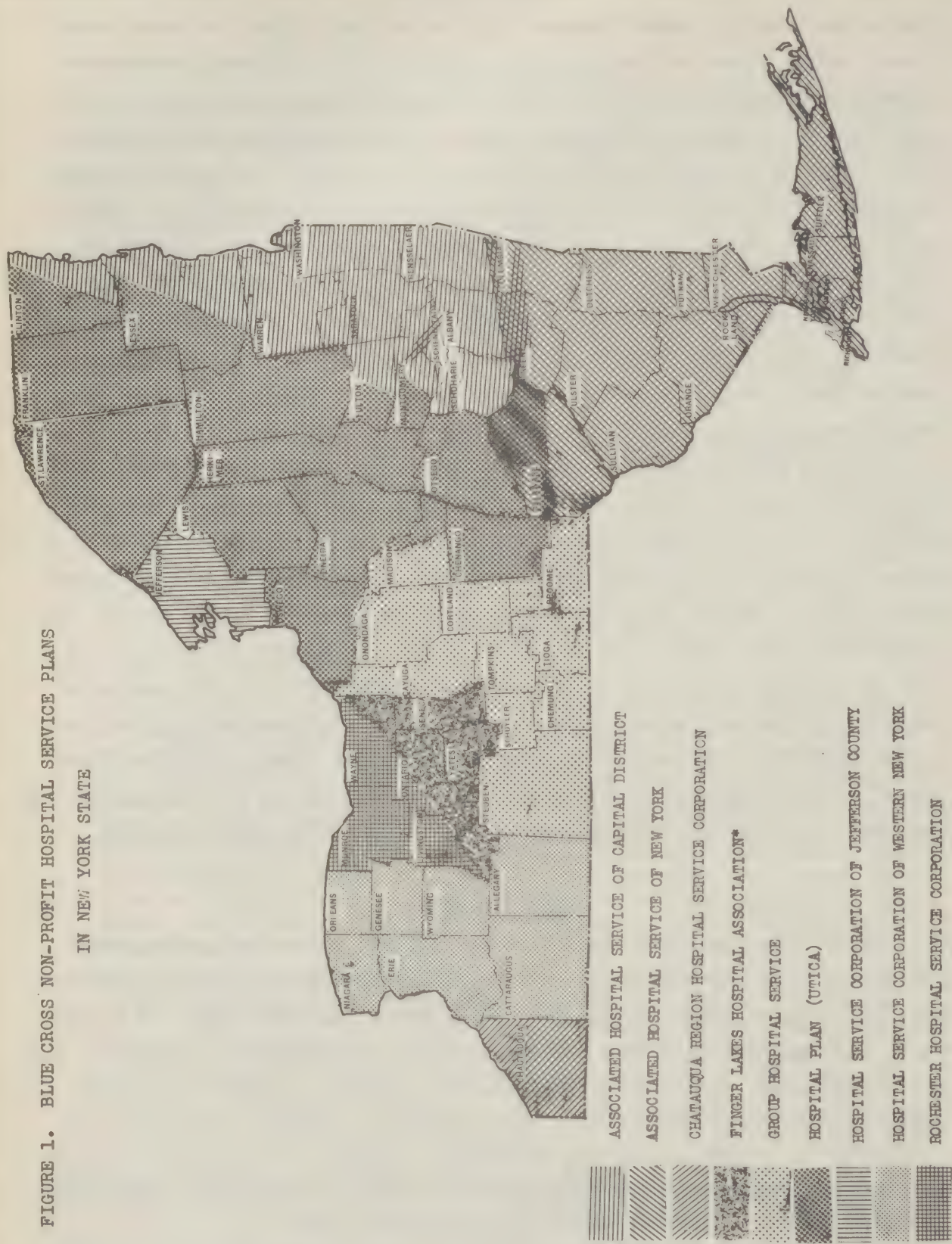
Legal Status

Except for fraternal benefit societies, and unions and associations of employees, non-profit organizations providing hospitalization insurance must be licensed under Article 9-C of the State Insurance Law. If a plan is to be organized under the Membership Corporations Law, the consent of the State Department of Social Welfare must be obtained. Whether organized under this or under Article 7 of the Cooperative Corporations Law, a license must be obtained from the State Superintendent of Insurance and the

2/ Non-profit Hospital Service Plans, C. R. Rorem, Commission on Hospital Service, American Hospital Association, Chicago, 1940.

3/ This restriction has led to difficulties in defining hospital service, especially with respect to anesthesiology, pathology, radiology, and physiotherapy, which the organized medical profession wishes to have excluded from hospital service plan benefits.

FIGURE 1. BLUE CROSS NON-PROFIT HOSPITAL SERVICE PLANS
IN NEW YORK STATE



*Merged with Rochester Plan, Nov. 1, 1945

operation of the plan must conform to the State Insurance Law.

The law terms these plans "non-profit hospital service plans", and defines hospital service as consisting of

hospital care provided through a hospital which is maintained by the state or any of its political subdivisions, or maintained by a corporation organized for hospital purposes under the law of this state, or such other hospitals as shall be designated by the State Department of Social Welfare, and hospitals of other states subject to the supervision of such other states,^{4/} or convalescent care provided by any convalescent institution.^{4/}

Medical expense indemnity and hospital service corporations may join in issuing a combined contract including both hospital and medical service, but neither of such corporations may alone issue a contract covering both types of benefits.^{5/} Not more than eighteen counties may be covered by any one plan.

Contracts and rates must be approved by the State Superintendent of Insurance. Contracts may cover either one person, a husband and wife, or husband, wife, and children not over 18.^{6/} Substantial reserves are required. Not more than 10 per cent of subscription payments may be paid in one year for soliciting subscribers, and not more than 20 per cent for additional administrative expenses. Solicitors may not be paid on a commission basis. Organizations which meet these requirements are exempted from all State, county and municipal taxes.

General Characteristics

The Blue Cross hospitalization insurance plans are administered by boards of directors, who serve without pay. Although there is no legal requirement relating to the composition of this board, hospital administrators are well represented, and physicians, subscribers and the public are usually represented. "Member hospitals" are those which enter into contracts with the Blue Cross plan in their area to provide specified services at a fixed rate to be paid by the plan, with no extra charge for these services being made to the patient. They agree also, to accept pro-rated payments from the plan, without recourse to the patient for the remainder of the bill, if the plan is financially unable to make full payments. The

^{4/} Article 9-C New York State Insurance Law. The language of the law implies the furnishing of hospital care rather than the payment of indemnity to the subscriber for care obtained by him.

^{5/} To date no such joint contract has been issued by any plan.

^{6/} Several plans arrange to cover dependents over 18 through "sponsored subscribers contracts" in which the billing is made to the principal subscriber, but the contract is issued to such dependent, who is termed a "sponsored subscriber".

major hospitals in the areas covered by a plan participate; public institutions and small privately-owned institutions usually are not member hospitals.^{7/}

Coverage

There are eight Blue Cross non profit hospital service corporations operating in the State.^{8/9/}

* Table 1. Blue Cross Non-profit Hospital Insurance Plans in New York State

Name of principal city	Name of plan
Albany	Associated Hospital Service of Capital District
Buffalo	Hospital Service Corporation of Western New York
Geneva ^{a/}	Finger Lakes Hospital Association ^{a/}
Jamestown	Chautauqua Region Hospital Service Corporation
New York City	Associated Hospital Service of New York
Rochester	Rochester Hospital Service Corporation
Syracuse	Group Hospital Service, Inc.
Utica	Hospital Plan, Inc.
Watertown	Hospital Service Corporation of Jefferson County

^{a/} This plan merged with the Rochester plan November 1, 1945. Since the merger is so recent, data for the Geneva plan have not been included with those for the Rochester plan.

Except for a few sparsely populated areas, the territory covered by each plan is exclusive; however, a person residing in one area may join a plan through a place of employment in another area. As of July 1945, the plans covered approximately 3.2 million persons, or 23 per cent of the population of the State (see Table 2). However, coverage was not evenly distributed throughout the State. Although there are many small rural communities where the percentage of the population covered is high, counties which are predominantly rural have for the most part very low coverage as compared with urban counties. As between urban areas, coverage varies greatly, depending on many factors. In Monroe County, for example, cover-^{7/} Hospitalization of subscribers in non-member hospitals within the area served by the plan is generally not covered by the contract, except in case of emergency. For hospitalization outside of the area, the subscriber has usually been reimbursed on an indemnity basis with a maximum per diem limit set on payments, no service benefits being available for such care. Recently, however, a number of the plans have concluded reciprocal agreements with other plans, so that service benefits may be obtained for hospitalization in other areas.

^{8/} For convenience, the various plans are referred to by the name of the principal city in the area covered by the plan. Thus, "the Buffalo plan" or "the Buffalo area", refers to the plan and entire area covered by the Hospital Service Corporation of Western New York. In the interest of simplicity this report deals in detail only with the six major plans, since the Jamestown, Geneva and Watertown plans have comparatively small enrollments, and the areas they cover are likewise small.

^{9/} The Geneva plan merged with the Rochester plan November 1, 1945. Thus, at present there are only eight plans in operation.

age is estimated as exceeding 50 per cent of the entire population, while in Onondaga and Erie Counties, coverage is between 20 and 29 per cent (see Figure 2).

Table 2. Membership in Blue Cross Plans in New York State, 1935-45 a/

Year, as of December 31	Number of participants				
	Albany	Buffalo	Geneva <u>d/</u>	Jamestown	New York
1935	-	-	-	-	40,439
1936	2,838	-	902	-	209,029
1937	10,659	16,213	1,059	1,330	555,894
1938	26,665	48,392	1,386	3,396	1,082,040
1939	44,237	97,009	1,996	6,754	1,358,409
1940	54,950	144,183	2,636	8,240	1,247,901
1941	67,772	198,902	3,145	10,884	1,292,104
1942	76,472	275,936	4,378	12,843	1,312,590
1943	93,536	334,389	6,010	16,176	1,412,978
1944	115,042	370,588	6,520	20,612	1,767,307
1945 <u>b/</u>	129,465 <u>c/</u>	374,600 <u>c/</u>	6,762	22,612	2,070,683
	Rochester	Syracuse	Utica	Watertown	All plans
1935	23,700	-	-	-	64,139
1936	55,033	8,446	-	-	276,248
1937	85,673	37,774	11,848	1,776	722,226
1938	109,059	66,772	30,690	2,473	1,370,873
1939	131,431	92,565	51,367	3,707	1,787,475
1940	153,755	100,529	68,983	4,485	1,785,662
1941	178,894	115,097	88,498	5,671	1,960,967
1942	204,059	131,387	94,138	6,217	2,118,020
1943	225,741	151,879	97,958	7,298	2,345,965
1944	253,298	170,544	102,342	9,219	2,815,472
1945 <u>b/</u>	255,916 <u>c/</u>	182,144	105,670 <u>c/</u>	10,293	3,158,145

a/ For percentage of population covered in these areas, see Table 3.

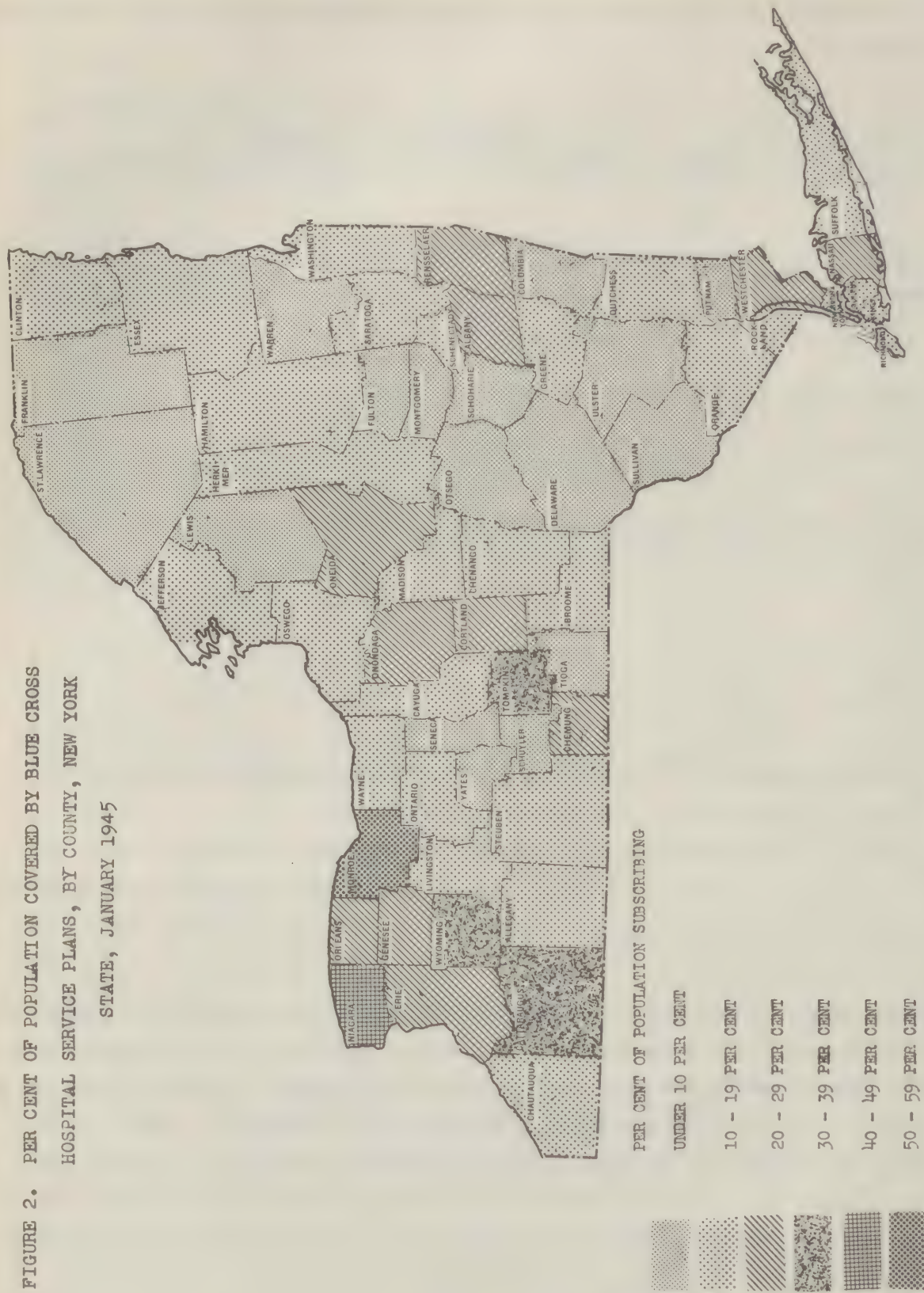
b/ As of July 1.

c/ Estimated.

d/ Merged with Rochester plan November 1, 1945.

The success of the Rochester Hospital Service Corporation in enrolling in Monroe County the highest proportion of population of any county of the State appears to be attributable to several factors peculiar to the Rochester area. First, the area is highly urban and employment is concentrated in relatively few establishments. Second, when the plan was organized, it was championed by the Rochester Industrial Management Council, consisting of the executives of the major industrial establishments. Their active support resulted in a rapid acquisition of subscribers in a period ten years ago, when the idea of hospitalization insurance was new and untried. The effect of this support can be seen in the concentration of membership in the 39 major industrial establishments in the city. As of January 1, 1945, three establishments, each employing 5000 or more persons, had 67.3 per cent of their employees covered, and accounted for 29.9 per cent of group enrollment. The 39 industrial firms employing 500 or more persons, and representing only 2 per cent of the total number of cooperating groups, accounted for 56.5 per cent of group subscribers. Continued support by the industrial leaders, together with cooperation of the hospitals and able

FIGURE 2. PER CENT OF POPULATION COVERED BY BLUE CROSS
HOSPITAL SERVICE PLANS, BY COUNTY, NEW YORK
STATE, JANUARY 1945



Note: The Five Counties of New York City are Tabulated Together
Source: Sample Surveys Made by Blue Cross Plans for the Commission

leadership, has achieved the present enrollment of some 256,000 participants.

There is no comparable situation in the rest of the State. In some areas, such as that covered by Group Hospital Service Inc. of Syracuse, there is wide use of commercial plans and company plans (such as the Endicott-Johnson Plan) which cover some type of health insurance, although such insurance in many instances is not as comprehensive in benefits. Another reason for low coverage in certain areas is the refusal of employers to adopt a payroll deduction system for employee hospitalization insurance payments. This is probably an important factor in the Buffalo area, where, with few exceptions, subscribers are accepted only through groups where the employer will arrange payroll deduction billings or, as an alternative, by other methods of group billing and remittance.

The average number of participants covered under each subscriber contract has increased steadily since the introduction of family contracts,^{10/} the average number of persons covered per contract at the present time being slightly more than 2.

Growth in Coverage

From the inception of non-profit hospital service insurance in New York State in 1935, there has been a steady and rapid growth. Table 3 shows for the area covered by each plan, and for the State as a whole, the percentage of population covered from 1935 to date.

Although this record of growth is impressive, the fact remains that many millions of residents do not have this form of protection. To reach a substantial proportion of those not covered, several methods were suggested by a study committee set up by the plans to make recommendations to the Commission on Medical Care.^{11/} In their report submitted on January 23, 1945, the following recommendations were made for increasing coverage through legislative action: make premiums deductible for income tax purposes; permit hospital service plans to issue one contract covering both medical and hospitalization insurance; require any employer to make payroll deductions for premiums if employees desire it;^{12/} permit selling of contracts on a commission basis; permit plans to join a rein-

^{10/} Many of the plans initially offered a contract covering only an individual. Later, contracts were offered covering a family, and in some instances, an additional type of contract covered only man and wife.

^{11/} Report of Study Committee Relative to New York State Temporary Commission on Medical Care, New York State Conference on Hospital Service Plans, January 23, 1945.

^{12/} Now required of municipalities by Chapter 428, Laws of 1945.

Table 3. Percentage of Population Covered by Blue Cross Plans in Their Respective Areas, New York State, 1935-1945

Per cent of population covered in various areas										
Year	Rochester	New York	Syracuse	Albany	Geneva	Utica	Watertown	James-town	Buffalo	Entire State
1935	4.6	-	-	-	-	-	-	-	-	-
1936	10.6	2.4	1.0	0.4	1.0	-	-	-	-	-
1937	16.5	6.2	4.7	1.4	1.2	2.7	2.1	1.1	1.4	5.4
1938	20.9	11.1	8.2	3.6	1.5	4.4	2.9	2.7	4.2	10.4
1939	25.1	15.0	11.3	5.9	2.2	7.4	4.4	5.5	8.3	13.2
1940	28.0	13.4	12.9	7.3	2.9	9.8	5.3	6.7	11.9	13.1
1941	34.0	14.0	14.0	9.0	3.4	12.7	6.7	8.8	17.9	14.3
1942	38.7	14.2	15.9	10.1	4.8	13.5	7.4	10.4	23.4	15.4
1943	42.5	15.2	17.9	12.4	6.5	13.9	9.7	13.7	27.0	16.9
1944	47.4	18.9	20.1	15.1	6.9	14.4	11.1	16.8	29.9	20.2
1945 ^a	47.6	22.0	21.3	16.9	7.2	14.8	12.3	18.3	30.1	22.7

a/ As of July 1.

insurance pool to spread risk throughout the State; require each hospital to submit a detailed financial report to a "Department of Hospitals"; authorize municipalities to purchase insurance for relief recipients; permit plans to furnish hospital out-patient diagnostic service of a technical nature; and authorize the State to lend money to municipalities for hospital construction. Although effecting these changes would probably serve to increase coverage by Blue Cross plans to some extent, the report concluded that to cover essentially all of the people of the State at an early date, it would be necessary to adopt legislation requiring the purchase of hospitalization insurance.^{13/}

^{13/} "In order that all or essentially all of the population in the State may be covered for hospital service at an early date, it will doubtless be necessary to enact legislation compelling the purchase of such coverage. To accomplish this end, all employers subject to the Workmen's Compensation law might be required to purchase on behalf of each employee coverage for non-occupational disabilities, whereby the employee would receive a benefit on admission to a ward similar to a compensation ward. Such legislature might go further, and require the purchase of benefits for the spouse and children of married employees, or such supplementary family coverage might be specified as an optional purchase to be available to the married employee. Aside from any general objections to the compulsory feature, certain factors should be considered:"

The factors listed included the need for additional bed facilities, particularly in private wards; adequacy of medical, nursing and hospital personnel; modified policies regarding charges by physicians for services to ward patients; the cooperation of certain hospitals now unwilling to render all service called for by Blue Cross contracts; minimum benefits to be required of all insurers, non-profit and private, and the difficulty requiring the latter to provide service rather than indemnity benefits; and the possible necessity of establishing a State fund to accept risks refused by existing insurance agencies.

Eligibility for Coverage

Although group membership was an eligibility requirement in the early stages of development of most of the plans, it is enforced only in the Buffalo area at present. There, with a few exceptions for professional groups, a subscriber must be an employee of a firm willing to arrange for payroll deduction billing. In the Albany area, only employed persons may join as subscribers, although group affiliation is not necessary. Other areas permit non-group enrollment, although careful screening may be made of applicants in this category.

A fixed minimum percentage of eligibles must enroll if a group is to be accepted at the group rate, which is lower than the non-group subscription rate. For example, in the Rochester area the minimum size of group is 5, of which 100 per cent must subscribe; for groups of 6 to 10 persons, 100 per cent less one person is the minimum; for groups of 11-25, 75 per cent; for groups of 25-50, 60 per cent; and for groups of over 50, 50 per cent. Minimum percentage enrollment requirements in other plans are very similar. This proportion does not have to be maintained, however, after original acceptance of the group.

Further limitations may be imposed on new applications.^{14/} Most plans do not accept as new members persons who are 65 and over. Only the spouse and unmarried dependents under 18 are covered on "family contracts", although several plans offer "sponsored subscriber" contracts for dependents over 18. Existing physical condition or previous illness may preclude membership. For example, in the Rochester area, under the new contract effected May 1, 1945, persons are eligible for membership only after a one-year waiting period if they have pernicious anemia, aneurysm, angina pectoris, apoplexy, Buerger's disease, coronary thrombosis, decompensated heart disease, diabetes, leukemia, mental disease, muscular dystrophy, organic disease of the central nervous system, or venereal disease; or if they have had epilepsy unless free from attack for three years, malignancy unless cured for five years, osteomyelitis unless cured for five years, tuberculosis unless inactive for two years, or ulcer unless healed for two years. In the Buffalo plan, persons who have had cancer, osteomyelitis or diabetes are not eligible. The Syracuse and Utica plans, under certain circumstances admit persons with existing or previous illnesses such as tuberculosis, but waive benefits for treatments relating to or arising from these conditions. Limitations such as these, in addition to the

^{14/} Certain plans waive these limitations in the case of groups which have a 75 per cent enrollment.

right of a plan to reject any application or to refuse a contract renewal to any subscriber,^{15/} and the fact that a majority of those enrolled are employed contribute to a more favorable selection of risks and smaller per capita expenditures than would be the case in insuring the entire population. To maintain premiums at a level attractive to large numbers of persons, favorable selection of risks appears necessary, especially in the early period of development of such plans. For example, as a result of individual enrollment of too great a number of poor risks in respect to disease, and of the enrollment on an unsatisfactory basis of healthy couples for maternity benefits, the Associated Hospital Service of New York was in 1939 forced to prorate payments to hospitals at 75 per cent of the scheduled rate.^{16/} To relieve this situation it was necessary to cancel 200,000 contracts of individual subscribers, and those individuals who were permitted to maintain non-group membership were charged a rate 20-25 per cent greater than the group rate.^{17/} Since that time, applications for individual enrollment have been carefully screened before a contract is issued.

Comparison of Blue Cross Subscribers With the General Population

A study was made of subscribers to the major Blue Cross plans in New York State, in respect to age, income and occupation, which are important factors in enrollment and utilization of service. Data were not obtained from the Jamestown, Watertown and Geneva plans because of their small enrollment, and data for the Albany plan could not be used because of an unusually low proportion of returns in that area. The figures are based on random samples of approximately 1000 subscribers to each plan. The data analyzed are from returns by group subscribers only, because very few returns were made by individual subscribers, because one plan could furnish data only on group subscribers, and because for purposes of comparison of income data group subscribers are more nearly comparable with the unemployment insurance group. With one exception, individual subscribers are numerically unimportant, being under 1, 5, 1, 1, and 29 per cent of the total subscribers for Buffalo, New York, Rochester, Syracuse and Utica respectively.

^{15/} Article 9-C of the State Insurance Law prohibits issuance of contracts for a period of more than one year but, according to executives of the plans, the right of refusal is very seldom exercised.

^{16/} The amount which was prorated was paid back in full to the hospitals at a later date.

^{17/} At a later date it was possible to reduce this rate to the same rate paid by directly-billed group subscribers.

The returns from the survey of group subscribers were very good for an undertaking of this type, the yield being shown in Table 4.

Table 4. Sample Survey of 1944 Wages and Salaries of Group Subscribers of Selected Blue Cross Plans - Size of Sample Taken and of Returns Used.

Questionnaires	Blue Cross plans				
	Buffalo	New York	Rochester	Syracuse	Utica
Total number	844	1000	860	1002	1000
Returned completed, per cent	90	65	86	88	70
Returned incomplete, " "	5	19	6	7	13
Not returned " "	5	16	8	5	17

Table 5 indicates that the Blue Cross plans cover a disproportionately great number of younger adults, who constitute a relatively healthy segment of the population, and a relatively small percentage of persons over 65 years of age, who would require more hospital care than persons in the younger age groups.

Table 5. Distribution of Male Subscribers and Male Population by Age for Rochester, Buffalo and Syracuse Blue Cross Areas, and of all Participants and Total Population for the New York City Area.^{a/}

Age group	Per cent of males						Per cent of all persons	
	Buffalo		Rochester		Syracuse		New York	
	Sub-scriber	Popu-lation	Sub-scriber	Popu-lation	Sub-scriber	Popu-lation	Partici-pants	Popu-lation
18-19	1	2	0	2	0	3	25 ^{b/}	29 ^{b/}
20-34	39	23	23	21	26	21	20	23
35-44	32	21	32	20	32	20	25	17
45-54	20	25	24	25	22	24	18	15
55-64	8	16	16	18	14	17	9	9
65 and over	0	13	5	14	6	15	3	7
Total	100	100	100	100	100	100	100	100

^{a/} Represents all subscribers for Rochester and Buffalo; represents group subscribers only for Syracuse and New York.

^{b/} All under 20, rather than 18-19 years of age.

The data on Blue Cross subscriber income are based on actual wages and salaries where the subscriber was employed for the full year at one establishment. Where he was employed at one establishment for most of the year (over eight months in most cases), the actual wage or salary for the period of employment was supplemented by an estimate, based on previous earnings, to give a figure for the full year, but where the subscriber was employed at one particular establishment for only a short period of time, the questionnaire was discarded as incomplete (see Table 4). A completely suitable basis for comparison would require a similar survey of the general population without regard to Blue Cross enrollment, but a survey of this

type has not been made since the 1940 Census. Lacking recent data, it has been necessary to utilize figures on the earnings of New York State residents under Unemployment Insurance, which suffer from the limitation that they include only wages and salaries received in covered employment, and exclude such wages or salaries as might be earned if the employee were engaged for a part of the year in other types of employment.^{18/} It nevertheless appears from a study of related data that a reasonably good basis for comparison is afforded. In 1942 and 1943 (the only other years for which this distribution is available) the figures are almost identical with data for workers in New York State covered by Old Age and Survivors Insurance. The latter seems to be a good indication of total wages from all types of employment since, when the comparison shown in Table 6 is made, remarkably little difference is seen.

Although the 1944 figure of 33 per cent of workers with income under \$1000 may appear high, it corresponds with the trend shown by 57 per cent for 1939 reported by the U. S. Census, and the figures of 56, 51, 49, and 48 percent reported for Old Age and Survivors Insurance for the years 1940, 1941, 1942 and 1943, and would seem suitable for comparison. Figure 3 and Table 7 show that a striking difference exists in the distribution of income be-

tween Blue Cross plan group subscribers and the persons covered by Unemployment Insurance. The difference is so marked that after all the limitations of the comparison have been acknowledged and the most extreme type of comparison employed, as has been done in Table 8, which redistributes the two groups after completely eliminating persons earning less

Table 6. Percentage Distribution of New York State Workers by 1939 Wage and Salary Classes, for Persons Covered by Old Age and Survivors Insurance and as Reported in the Federal Census.

Wage or salary	OASI ^{a/}	Census ^{b/}
Under \$1000	56	57
1000-1499	18	19
1500-1999	12	10
2000-2499	6	6
2500-2999	3	3
3000 and over	5	5
Total	100	100

a/ Old Age and Survivors Insurance Yearbook, Social Security Board, 1939.

b/ U. S. Census of Population, Third Series, the Labor Force, 1940.

^{18/} In employment covered by a somewhat similar law, Old Age and Survivors Insurance, in an earlier year, 1941, 62.5 per cent had covered wages throughout the year, 14.6 per cent for 3 quarters of the year, 12.1 per cent for 2 quarters and 10.8 per cent for 1 quarter. A considerable proportion of the persons who were not employed in covered employment for a portion of the year was attributable to absence from any gainful occupation, over 0.5 million persons being compensated for more than 5 million weeks of unemployment. Social Security Yearbook, 1942, Social Security Board, Washington.

Figure 3. Percentage Distribution by 1944 Wage and Salary, of Group Subscribers of Selected Blue Cross Plans and of Persons Covered by Unemployment Insurance in New York State

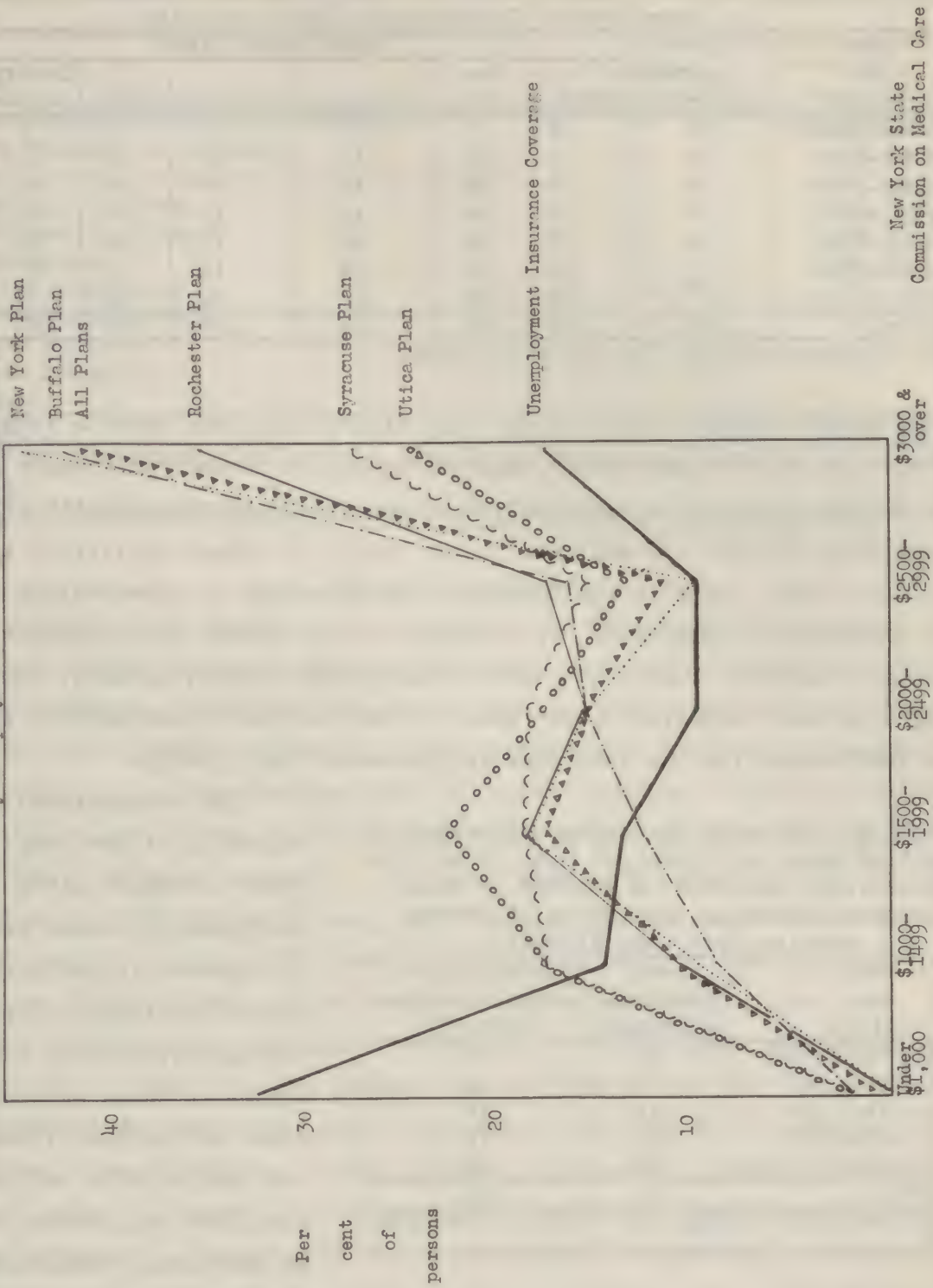


Table 7. Comparison of Percentage Distribution by 1944 Wage and Salary, of Group Subscribers of Selected Blue Cross Plans with Persons Covered by Unemployment Insurance in New York State

Wage or salary	Unemployment Insurance	Blue Cross plans					Entire State
		New Buffalo	New York	Rochester	Syracuse	Utica	
Under \$1,000	33	2	0	0	2	2	1
1,000-1,499	15	9	10	11	18	18	11
1,500-1,999	14	13	19	19	17	23	18
2,000-2,499	10	16	16	16	19	18	16
2,500-2,999	10	17	10	18	16	14	12
3,000-3,999	()	28	18	24	18	15	20
4,000 & over	(18)	15	27	12	10	10	22
Total	100	100	100	100	100	100	100

a/ Weighted average for the five plans.

than \$1,000 annually, it is clear that Blue Cross plans cover a very low proportion of the numerically important group of workers with wages under \$1,500 per year, and a relatively high proportion of persons with earnings above \$3,000. In addition to the factor of actual ability or inability to pay, there is the factor of the advantage or disadvantage in the purchase of insurance. If premiums are not graded in accordance with income, insurance costs the lower income groups relatively more, and the higher groups relatively less, than the amounts they would have to pay on the average for the same service purchased individually.

Table 8. Adjusted Percentage Distribution by 1944 Wage and Salary, of Blue Cross Plan Subscribers and Persons covered by Unemployment Insurance, Exclusive of Persons earning Less than \$1,000.

Wage or salary	Unemployment Insurance	Blue Cross plans - entire State a/
\$1,000-1,499	22	11
1,500-1,999	20	18
2,000-2,499	15	16
2,500-2,999	15	12
3,000 and over	28	43
Total	100	100

a/ Weighted average for Buffalo, New York, Rochester, Syracuse and Utica plans.

The occupational distribution of New York State's workers since 1940 has probably tended toward an increase in the proportion of craftsmen, foremen and operatives, and a decrease in sales personnel. After making due allowance for such a shift and the fact that this study covered only group subscribers, it appears, as indicated

in Table 9, that relatively few farmers, domestics and unskilled workers are covered by Blue Cross plans. Professional and semi-professional persons (teachers represent a large proportion of the group), being those of higher-than-average income or more than usually well-informed, make up a disproportionately large number of the insured.

Table 9. Percentage Distribution by 1944 Occupation of Group Subscribers of Selected Blue Cross Plans and by 1940 Occupation of the New York State Population.

Occupation	Blue Cross Plans, 1944 ^{a/}	State population, 1940 ^{b/}
Professional and semi-professional	14	9
Farm managers & laborers	0	4
Proprietors & managers, excluding farm	10	10
Clerical & sales	40	23
Craftsmen & foremen	14	12
Operatives	15	20
Domestic service	0	5
Protective service	1	2
Other service	3	9
Other laborers	2	5
Others	1	1
Total	100	100

a/ Weighted average for Buffalo, New York, Rochester, Syracuse and Utica plans.

b/ U. S. Census of Population, Third Series, the Labor Force, 1940.

Cost of Insurance

Depending on his place of residence, the purchaser of Blue Cross hospitalization insurance may pay different amounts for protection and receive differing percentage returns in service, not in all cases related to the amount of premium payments. Comparative costs of insurance can be evaluated only after consideration of annual premiums, benefits provided, eligibility provisions and local conditions affecting costs of administration and of hospital service. The plans vary considerably in all of these factors. In the following text, data on premiums and benefits are based on current contracts, while data on income and costs of administration are based on 1943 and 1944 operations; since that time benefit provisions of several of the plans have been liberalized. Data on premiums charged are presented in Table 10. The percentages of premium used for hospitalization costs, administrative costs and reserve are indicated in Table 11. The cost of administering a plan does not increase in direct proportion to the amount of benefits provided; thus a plan with fewer benefits and lower premiums, although efficiently administered, may require a greater proportion of premiums for administrative purposes. It is therefore **important** to consider the dollar cost of administration per participant, and the income and hospital expense per participant, as shown in Table 12, in addition to the cost as a percentage of the premium dollar.

The rates of payment to hospitals are shown in Tables 13 and 14. These rates are set after an agreement is reached in conference between the participating hospitals and the Blue Cross plans.

Table 10. Annual Premiums Charged by Major Blue Cross Plans for Semi-Private Contracts as of November 1945.

Plan	Group (payroll deduction)			Group conversion			Individual	
	Single	Two person	Family	Single	Two person	Family	Single person	Two person
Albany a/	\$10.00	\$18.00	\$24.00	\$10.50	\$19.00	\$26.00	\$10.50	\$19.00
Buffalo	9.00	16.20	21.60	9.00 b/	16.20 b/	21.60 b/	-	-
New York	9.60	19.20	24.00	10.00	20.00	26.00	10.00	20.00
Rochester	9.60	-	22.80	11.00	-	24.00	12.00	-
Syracuse c/	7.80	16.20	19.20	10.00	-	24.00	10.00	-
Utica	8.40	13.20	15.60 d/	10.00	16.00	19.00 d/	10.00	16.00

a/ Sponsored subscribers are billed at the single person rate.

b/ Billed either quarterly or annually, with a \$.10 service charge for each billing.

c/ Sponsored subscribers are billed at \$3.40.

d/ Premiums of \$4.80 for each dependent 16 to 18 and for sponsored subscribers for payroll deduction groups, and \$6.00 for each persons for group conversion and individually enrolled subscribers.

Explanation of table: Group rates are given only for groups where payment is made through payroll deduction or some other form of group billing and remittance. Where groups are accepted for direct billing of the individual, the rate may be higher. "Group conversion" consists of persons joining through a group but subsequently leaving the group. Such persons are permitted to retain membership, generally at a slightly higher premium. Payroll deduction groups are generally billed monthly or quarterly, while direct payment subscribers are generally billed for longer periods of time. All the plans offer service benefits in semi-private accommodations; in addition to this, the Buffalo, Utica, and New York plans offer lower priced contracts providing hospital service in ward accommodations.

Table 11. Percentage Distribution of Premium Dollar by Hospital Service Plans in 1944 (Computed on an Accrual Basis).

Plan	Hospital service	Distribution of Income				Reserve	Total
		Total	Administration		Other		
			Promotion				
Albany	76	9	-	-	-	15	100
Buffalo	80	12	-	-	-	8	100
New York	76	14	-	-	-	10	100
Rochester	85	11	2	9	4	10	100
Syracuse	78	11	1	10	11	10	100
Utica	69	16	6	10	15	10	100

Note: In comparing these data it is important to consider that several of these plans have been administering non-profit medical indemnity plans under contract with non-profit medical indemnity corporations. Although the greater volume of accounts permits some economies of service to the hospital plan, administration of the medical plans is somewhat more expensive than of hospital service plans, and as a result of the procedure usually followed, of dividing administrative costs between the hospital and medical plans on a percentage basis according to amount of premium income, the Blue Cross plans frequently assist the medical plans financially to some extent.

Table 12. Income, Hospital Expense and Administrative Expense per Participant of Blue Cross Plans in 1943 and 1944.

Plan	1943			1944		
	Income	Hospital expense	Administrative expense	Income	Hospital expense	Administrative expense d/
Albany	\$7.93	\$5.68	\$.67	\$7.98	\$6.01	\$.71
Buffalo a/	5.96	4.89	.67	e/	e/	.72
New York a/	8.20	6.24	1.12	8.05	6.13	1.15
Rochester	5.71	4.72	.63	5.59	4.69	.63
Syracuse	6.23	4.11	.66	6.15	4.23	.69
Utica a/	e/	e/	.90	5.39 b/	3.78 c/	.79

a/ Includes ward service contracts.

b/ \$5.55 for semi-private and \$3.37 for ward contracts.

c/ \$3.85 for semi-private and \$2.99 for ward contracts.

d/ Data on administrative expense per participant are available in Experience of Blue Cross Hospital Service Plans for 1944 only, as follows: Albany \$.65; Buffalo \$.68; New York \$1.03; Rochester \$.60; Syracuse \$.65; and Utica \$.77. The variation of these figures from those included in the table is the result of the use of a different method of computation.

e/ Data not available.

Explanation of table. Data on income and hospital expense are taken from the 1943 and 1944 volumes of Experience of Blue Cross Hospital Service Plans, Hospital Service Plan Commission, American Hospital Association. Administrative expense per participant is the total administrative cost, on an accrual basis, as listed in the respective volumes of Experience of Blue Cross Hospital Service Plans, divided by the number of participants. The number of participants is the December 31 enrollment of the preceding year plus one-half the increase in membership during the year, as shown in Table 2.

Table 13. Rate of Payment by Blue Cross Plans to Participating Hospitals for Semi-private Accommodations, Excluding Maternity Care, as of November 1945.

Plan	Length of hospital stay					
	1 day	2 days	3 days	More than 3 days		
				Daily after 3rd day	Daily incl. 1st 3 days	Total for 10 days
New York City g/	\$15.00	\$25.00	\$34.00	a/	-	\$85.00
Buffalo	b/	b/	b/	b/	-	b/
Rochester						
Rochester hospitals c/	8.00	16.00	24.00	\$2.00	-	80.00
Non-Rochester hospitals c/	6.75	13.50	20.25	6.75	-	67.50
Syracuse	11.00	15.00	13.00	-	\$6.00 d/	60.00
Albany	15.00	20.00	24.00	-	6.00 e/	60.00-70.00 e/
Utica	11.00 f/	11.00 f/	16.50 f/	5.50 f/	-	55.00 f/

a/ After 3rd day, paid on a schedule as follows:

4 days \$42; 5 days \$50; 6 to 10 days \$7 per day for each additional day; after 10th day, \$6 per day for each additional day.

b/ Until May 1, 1945, paid \$12 for 1 day, \$18 for 2 days, \$20 for 3 days and \$6.25 for each day, thereafter. Currently, the plan pays the total bill for all benefits, less a 3 per cent discount.

c/ New rate starting May 1, 1945. Rate is different for hospitals in the city of Rochester and those in the rest of the area.

d/ Contract with hospitals calls for \$5.50; however, \$6.00 is currently paid because of higher hospital costs during the war.

e/ Every 6 months payment is made to hospitals of difference between payment to hospitals and regular billings less 3 per cent up to \$7 a day.

f/ Payment for dependents is \$2 less per day, since dependent is charged \$2 per day for hospitalization.

g/ For the year 1945, \$400,000 will be paid on a pro rata basis to member hospitals which realize a loss on the basis of charges on plan admission.

Table 14. . Rate of Payment by Blue Cross Plans to Participating Hospitals for Maternity Care in Semi-private Accommodations, as of November 1945

	Per diem payment	No. of days covered
New York City	\$6.00	10
Buffalo	Regular service benefits	
Rochester	6.00	10
Syracuse	3.50	14
Albany	6.00	10
Utica	4.00	10

Benefits Provided

An analysis of benefit provisions of the individual plans is presented in Table 15. All plans include hospital bed and board in semi-private accommodations for varying lengths of time,^{19/} general nursing care as provided by the hospital, operating room, laboratory service and drugs and dressings. Some plans include, in addition, physical therapy, ambulance (for limited cost or limited area of service), anesthesia by a salaried hospital employee only, electrocardiogram, basal metabolism, x-ray, serum and oxygen. All plans provide hospital care in the emergency department of hospitals for accidental injuries when the patient is not admitted as a regular bed-patient.^{20/}

Inclusion of anesthesia and x-ray in hospital service contracts has been contested by the medical profession in several areas. In the Buffalo area, for example, the Executive Director in his annual report to the Board of Directors^{21/} stated that

(there is an option to) provide a contract ... which does pay all of the usual charges appearing on a hospital bill ... I believe this program would have been an accomplished fact if it were not for the consistently vigorous opposition thereto on the part of spokesmen for the medical profession.

With certain exceptions, benefits are provided on a service basis, with all benefits provided by the plan paid for in full. The hospital agrees to make no additional charge to the patient for these benefits, although it may charge the patient for services not covered by the contract. The benefits provided may, however, be limited to a maximum

^{19/} In addition, the New York, Utica, and Buffalo plans issue a second type of contract which provides ward accommodations.

^{20/} Such care is limited to 12 to 24 hours and may include use of operating room, anesthesia, dressings, etc. A maximum is imposed upon costs paid.

^{21/} Eighth Annual Report of the Hospital Service Corporation of Western New York for the Year Ended December 31st, 1944.

Table 15. Principal Hospital Benefits Included in Blue Cross Plan Contracts under Semi-private Coverage.

Benefits	Blue Cross plan					
	Albany	Duffalo	New York	Rochester	Syracuse	Utica
Room and board - days:						
complete benefits	60 <u>o</u> /	30	21 <u>o</u> /	30	30 <u>h</u> /	25 <u>r</u> /
partial benefits	60	No limit <u>s</u> /	130	90	60	65 <u>r</u> /
General nursing	Yes	Yes	Yes	Yes	Yes	Yes
Operating room	Yes	Yes	Yes	Yes	Yes	Yes
Laboratory services	Yes	Yes	Yes	Yes	Yes	Yes
Physiotherapy	Yes	No	Yes	Yes	No	No
Drugs and dressings <u>a</u> /	Yes	Yes	Yes	Yes	Yes	Yes
Ambulance	Yes	Yes	No	Yes	Yes	Yes
X-ray (diagnostic)	Yes <u>a</u> /	No	Yes	No	No	No
Anesthesia by salaried hospital employee	Yes	No	Yes	Yes	No	No
Electrocardiogram	Yes	No	Yes	Yes	No	No
Metabolism	Yes	Yes	Yes	Yes	No	No
Serum and oxygen	No	Yes	Yes	Yes	No	No
Radium	No	No	No	No	No	No
Blood for transfusion	No	No	No	No	No	No
Special nursing	No	No	No	No	No	No
Emergency treatment	Yes <u>f</u> /	Yes <u>f</u> /	Yes <u>f</u> /	Yes <u>f</u> /	Yes <u>f</u> /	Yes <u>b</u> / <u>f</u> /
Out-patient service	No	No	No <u>n</u> /	No	No	No
Delivery room	No	Yes	No	No	No	No
Maternity	Yes <u>b</u> / <u>c</u> / <u>d</u> /	Yes <u>b</u> / <u>m</u> /	Yes <u>b</u> / <u>c</u> / <u>d</u> /	Yes <u>b</u> / <u>c</u> / <u>l</u> /	Yes <u>a</u> / <u>c</u> / <u>l</u> /	Yes <u>b</u> / <u>c</u> / <u>m</u> /
Tonsillectomy	Yes	Yes	Yes <u>b</u> / <u>e</u> / <u>f</u> /	Yes <u>b</u> / <u>e</u> / <u>f</u> /	Yes <u>a</u> / <u>e</u> / <u>f</u> /	Yes <u>a</u> / <u>f</u> / <u>m</u> /
Pre-existing conditions	Yes <u>e</u> /	No <u>w</u> /	Yes <u>b</u> / <u>f</u> / <u>m</u> /	Yes <u>b</u> / <u>f</u> / <u>m</u> /	Yes <u>a</u> / <u>f</u> / <u>m</u> /	No
Pregnancy complication	Yes <u>v</u> /	Yes <u>b</u> / <u>m</u> /	Yes <u>b</u> / <u>x</u> / <u>d</u> /	Yes <u>b</u> / <u>c</u> /	Yes	Yes <u>b</u> / <u>c</u> / <u>m</u> /
Communicable diseases	Yes <u>k</u> /	No <u>w</u> /	No	No	Yes <u>p</u> /	Yes <u>b</u> / <u>c</u> / <u>m</u> /
Plastic surgery						
new conditions	Yes	Yes	Yes	Yes	Yes	Yes
pre-existing conditions	No	No	Yes <u>b</u> /	No	No	No

a/ Limited benefits.b/ After waiting period.c/ On indemnity basis.d/ On family contract with group enrollment.e/ For limited period.f/ For limited cost.g/ After 6 months if person did not need treatment prior to enrollment.h/ After first year.k/ \$6 per day up to 10 days in member hospital for scarlet fever, diphtheria, smallpox, asiatic cholera, bubonic plague, typhus fever, meningococcus meningitis.l/ On family contract only.m/ On family and two person contract.n/ Allowance to subscribers needing operating room service but who are not bed patients.o/ Allowed in each illness.p/ Poliomyelitis, scarlet fever, epidemic meningitis, diphtheria and smallpox, on service basis if in participating hospital and indemnity if in non-participating hospital.q/ After waiting period. Waiting period waiver for groups with large proportion of subscribers.r/ For fracture cases, 42 days full benefits and 48 days partial benefits.s/ In participating hospitals only.t/ After 6 months if person did not need treatment before enrollment.u/ No elective operations such as plastic surgery for pre-existing conditions.v/ Limited to indemnity benefits for limited period excepting that ectopic pregnancies and caesarean sections receive regular service benefits.w/ Not in contract, but allowed in practice.x/ Service benefits if pregnancy is accidentally terminated.

dollar value, as is often the case with x-ray. For maternity,^{22/} contagious diseases,^{23/} out-of-area hospitalization except where reciprocal agreements with other plans are in effect, and in some instances hospitalization where private accommodations are used instead of semi-private or ward,^{24/} service is on an indemnity basis, i.e., the plan allows a maximum per diem rate for such hospitalization and the patient must pay the remainder of the bill.

Contagious diseases which are excluded from service benefits, or excluded from coverage entirely, are defined to mean those requiring isolation. Such cases are usually not treated in participating hospitals. Benefits are ordinarily provided for cases, such as poliomyelitis, which are admissible to participating hospitals.

Cases covered by Workmen's Compensation laws, and those the care of which is provided for by law in public facilities (mental and nervous disorders, tuberculosis, etc.) are not covered by any of the plans. In the case of tuberculosis, which is not covered by benefits after diagnosis, benefits are usually provided while the patient is awaiting admission to a sanatorium.

A measure of the adequacy of benefits is the financial burden removed from the participant in the Blue Cross plan. Table 16 indicates the amount of the hospital bills incurred by Blue Cross participants of several plans in 1944.^{25/}

A large majority of the bills are under \$100. The Blue Cross plans pay a large proportion of this type of bill, while the individual pays rather nominal sums, as indicated in Table 17. For bills over \$100, the proportionate cost to the individual is much greater, and may total several hundred dollars.

^{22/} The Buffalo plan is an exception to this. It is the only plan which provides service benefits for maternity cases.

^{23/} Syracuse provides this as a service benefit if hospitalized in a participating hospital.

^{24/} Some of the plans permit use of private accommodations, with all service benefits provided and the patient charged extra only for the added cost of the room. Other plans, when private accommodations are used, provide indemnity benefits at a flat per diem rate, and the patient must pay the hospital bill over this amount.

^{25/} This is not the amount for which the Blue Cross plans are billed, since their billing is on a per diem basis, as indicated in Table 13. It is the amount the individual would have to pay if he were not a Blue Cross participant. These bills are only for illnesses covered by the respective plans, thus the individual may be paying in full other hospital bills which are not covered by the contract.

Table 16. Percentage Distribution of Hospital Bills of Blue Cross Plan Participants by Amount of Bill, 1944.

Amount of bill	Blue Cross plans				
	Alb-a/ any	Buff- alo	Roches- ter	Syra- cuse	Utica
Under \$50	45	35	44	68	66
50-99	34	47	31	21	29
100-199	17	14	20	10	5
200-299	2	2	4	1	0
300 & over	2	2	1	0	0
Total	100	100	100	100	100

a/ For first 8 months of 1944 only.

or may be at a flat per diem rate, are excluded. The bills do not include professional fees. In some areas, anesthesia and x-ray are billed by the doctors rather than the hospitals, which tends to lower the average hospital bill in such areas.

For the New York City plan, comparable data on amount of hospital bill are not available, however for 1944, the average hospital charges for maternity cases where semi-private accommodations were used totalled \$95, and for non-maternity cases, \$98.

The distribution of hospital bills by amount of bill for the Blue Cross participants is not necessarily identical with that for the public as a whole, as Blue Cross participants tend to be hospitalized more frequently, although for shorter periods, which tends to make their bills smaller than those of non-participants.

Table 17. Average Payment Made by Subscriber, in Addition to the Amount paid by Blue Cross, for Claims by Amount of Bill, 1944.

Amount of bill	Alb-a/ any	Buff- alo	Roches- ster	Syra- cuse	Utica ^{c/}
Under \$50	1	3	4	6	4
50-99	8	8	15	9	17
100-199	19	33	18	26	30
200-299	55	72	40	150 ^{d/}	-
300 & over ^{b/}	160	281	368	250 ^{d/}	-

a/ For first 8 months of 1944 only.

b/ Because of the small number of cases in the sample falling in this category, the items are representative of only a few claims, rather than constituting an accurate sample of the class.

c/ Includes the \$2 per day charged the participant for hospitalization of a dependent.

d/ Estimated

under \$50 to 74 per cent for bills over \$300, while for bills for in-area-hospitalization the participant paid only 15 per cent to 60 per cent respectively.

For New York City, where comparable data are not available, payments on maternity bills averaged \$34 of the \$95 average bill and \$13 of the \$98 average non-maternity bill.

Thus, Blue Cross pays from 50 to 95 per cent of hospital charges to participants in cases covered by the contract. The lower the bill, the greater the proportion covered. Variations are due to type of benefits

Explanation of table.

Data are based on sample surveys made by five of the Blue Cross plans for the Commission on Medical Care. The bills are those in which semi-private accommodations were used within the area served by the plan, i.e., bills from hospitals out of the plan's area, for which Blue Cross payments are

The bills do not include

professional fees. In some areas, anesthesia and x-ray are billed by the doctors rather than the hospitals, which tends to lower the average hospital bill in such areas.

For the New York City plan, comparable data on amount of hospital bill are not available, however for 1944, the average hospital charges for maternity cases where semi-private accommodations were used totalled \$95, and for non-maternity cases, \$98.

The distribution of hospital bills by amount of bill for the Blue Cross participants is not necessarily identical with that for the public as a whole, as Blue Cross participants tend to be hospitalized more frequently, although for shorter periods, which tends to make their bills smaller than those of non-participants.

Explanation of table.

Data are based on same sample as Table 16.

Data are on bills from hospitals in the Blue Cross plan's areas, for which semi-private accommodations were used.

For the Buffalo plan, an analysis of bills for claims from hospitals out of the Buffalo area reveals a significantly higher proportion of the bill paid by the individual for bills of all amounts, ranging from an average of 39 per cent for bills

under \$50 to 74 per cent for bills over \$300, while for bills for in-area-hospitalization the participant paid only 15 per cent to 60 per cent respectively.

For New York City, where comparable data are not available, payments on maternity bills averaged \$34 of the \$95 average bill and \$13 of the \$98 average non-maternity bill.

Thus, Blue Cross pays from 50 to 95 per cent of hospital charges to participants in cases covered by the contract. The lower the bill, the greater the proportion covered. Variations are due to type of benefits

covered by the plan, including the length of stay and the period over which Blue Cross covers essentially full benefits,^{26/} and the fact that some Blue Cross contracts limit the amount they pay for services other than bed and board, e.g., x-ray.

Ward Service

Three plans, Buffalo, New York and Utica, issue contracts providing ward accommodations, in addition to contracts providing semi-private accommodations.^{27/} The Buffalo plan has issued this type of contract since it began operations in 1937, Utica introduced ward contracts in 1938, and New York in 1943. The premiums, which are shown in Table 18, are significantly lower than those for semi-private contracts (see Table 10). There is no standard for eligibility for a ward contract, i.e., the subscriber has the option of taking either a ward or semi-private contract, regardless of his financial status. Service benefits under ward contracts are

Table 18. Premium Rates for Groups Enrolled on a Payroll Deduction Basis for Ward Contracts, 1945.

Plan	One person	Two persons	Family
Buffalo	\$7.20	\$13.20	\$17.40
New York	6.72	15.84	15.84
Utica	6.96	11.16	13.20

identical with those in semi-private contracts, except for the type of hospital accommodations. However, the per diem allowance for care in non-member hospitals, the allowance toward better

accommodations, and the indemnity benefits for maternity care^{28/} are lower than for semi-private contracts. For example, the Utica plan allows \$3.50 per day for maternity care under ward contracts and \$4 under semi-private contracts, and the New York plan allows \$4 and \$6 respectively. Plans offering ward contracts find that the number of participants per contract is higher for ward than for semi-private contracts, i.e., that persons with larger families can more readily afford the ward-type contract.

Although ward contract enrollment in the Buffalo plan constitutes about one-third of the total enrollment, in the Utica plan only 7 per cent

^{26/} In the Albany plan, where protection is complete for 60 days and where an additional 60 days at partial benefits is allowed, the cost to the individual is lowest of the plans examined. This is only a partial factor since benefits of the Albany plan are among the most comprehensive.

^{27/} Syracuse has a ward plan available to the public, but since 1940 only one group has requested ward contracts. This was the Farm Security Administration group in Steuben County which, after one year, changed to the semi-private contract.

^{28/} Except in the Buffalo plan, where maternity benefits are provided on a service basis.

of participants, and in the New York plan only several hundred of the 2 million participants, hold ward contracts. The popularity of the ward contract in the Buffalo area appears to be attributable to local arrangements regarding ward service. Most of the hospitals have six- or eight-bed wards, which are open to persons who pay their own physician; in fact, patients who can pay for their hospital accommodations are expected to employ their own physicians. This system, which affords low-cost hospital service, seems popular and does not entail the usual stigma of charity in relation to ward care.

In the Utica area, ward contracts have not been purchased in large number, although paying ward patients are permitted to engage their own physicians; however, during less prosperous periods, a somewhat larger proportion of persons have purchased ward contracts. The reason for the low proportion of ward contracts under these conditions may well be the very small differential between ward and semi-private contracts, which amounts to only \$.12 per month for single persons and \$.20 per month for families. Also the cost of semi-private contracts is relatively low in the Utica area as compared with other areas (see Table 10), so that Utica's semi-private contract on a family basis costs less than ward contracts in the New York and Buffalo plans.^{29/}

In New York, ward contracts have not been sold in any significant volume. This is readily explained, since in New York ward patients are not permitted to have their own physicians. Persons are admitted to wards only on the basis of a means test,^{30/} those who are able to do so being expected to pay for care. In a large proportion of cases little or no payment is made. Because the person holding a ward contract can be admitted to ward accommodations only if the hospital finds his financial status warranting this, and because once admitted, he receives no benefits that he would not otherwise obtain at no cost, there is no real advantage in ward service on a prepayment, insurance basis.

The experience throughout the country of Blue Cross plans offering ward as well as semi-private contracts is very similar to that in New York State.^{31/} In areas where ward contracts have been issued for a number of years, where there is a substantial difference between ward and semi-private contract rates, and where the sale of such contracts is promoted as actively

^{29/}The lower cost for Utica is the result of inclusion of fewer benefits in the contract.

^{30/}Ward patients receive physicians' services on a charity basis.

^{31/}Study of plans offering both ward and semi-private contracts, contained in Experience of Blue Cross Hospital Service Plans, 1942, 1943 and 1944 editions, Hospital Service Plan Commission, American Hospital Association.

as that of semi-private contracts, the ward contract attracts a proportion of subscribers comparable to that in the Buffalo plan. In addition, a powerful factor in New York State seems to be the privilege of a person holding a ward contract to engage and pay his own physician.

Utilization of Hospital Facilities

The utilization of hospital facilities by Blue Cross participants is significantly lower than that for the general population, as indicated in Table 19, despite the fact that hospitalization of persons who are not insured is often delayed or avoided because of financial considerations. It is noteworthy that although the per capita rate of hospital admissions for Blue Cross participants equals or exceeds that for the general public, the average length of stay is considerably less, so that the average days of hospital care per person is lower for Blue Cross participants. This probably results first from favorable selection of risks by Blue Cross plans, and second, as indicated by the higher rate of hospital admissions, the earlier hospitalization of persons in need of treatment, so that treatment is given before the condition becomes advanced and necessitates prolonged care.

Summary

In New York State as elsewhere in this country, the Blue Cross plans fulfill the needs and wishes of millions of people for a mechanism whereby they may equalize with their fellows some of the financial hazards of illness. The plans operating in this State seem to be well administered and sound in purpose, tending to increase their benefits as experience and financial stability is acquired. The fear expressed at the beginning of this venture into insurance against the costs of sickness, that a great amount of unnecessary hospitalization would result, does not seem to have been realized when comparison is made with hospital utilization by persons not so insured. Few plans offer ward contracts, and within these plans few such contracts are sold unless premiums are significantly lower and unless private physicians may be engaged, suggesting that people do not want to insure against the costs of hospital service unless they can afford to pay directly for, or insure against, the costs of physicians' services in the hospital.

As against their achievements, the plans seem to suffer from several deficiencies:

1. Premiums are not based upon such obvious actuarial factors as sex, risk of child-bearing and size of family, which tends to

Table 19. Annual Rate of Hospital Admissions, Average Length of Stay, and Average Days per Person, by all Residents and by Blue Cross Participants, New York State, 1942, 1943 and 1944.

Group	1942	1943	1944
Rate of admissions per hundred persons			
All residents ^{a/}			
Total	-	9.18 ^{e/}	9.82 ^{f/}
Adjusted total	-	8.54 ^{e/}	9.14 ^{f/}
Blue Cross participants ^{b/}	9.46 ^{c/}	9.39 ^{c/}	9.03 ^{d/}
Average hospital stay ^{g/}			
All residents	-	14.37 ^{e/}	13.67 ^{f/}
Blue Cross participants ^{b/}	9.53 ^{c/}	9.52 ^{c/}	9.85 ^{d/}
Hospital days per capita			
All residents ^{a/}			
Total	-	1.319 ^{e/}	1.316 ^{f/}
Adjusted total	-	1.228 ^{e/}	1.205 ^{f/}
Blue Cross participants ^{b/}	.887 ^{c/}	.887 ^{c/}	.855 ^{d/}

a/ Because admissions include out-of-State residents hospitalized in New York City, while the population base is for New York State, it was necessary to make an arbitrary correction by adding one million to the population of the New York City district to obtain the adjusted total for a valid basis of comparison with Blue Cross plan data.

b/ Figures derived from data in the 1942, 1943 and 1944 editions of Experience of Blue Cross Hospital Service Plans, 1942, Hospital Service Commission, American Hospital Association. Blue Cross figures are weighted averages based on experience of all plans in the State.

c/ Does not include data for the Utica plan, which were not available.

d/ Does not include data for the Rochester, Buffalo, Utica and Geneva plans, which were not available.

e/ Figures are based on data for 365 of the 470 general hospitals and maternity homes, etc. in the State. Hospitals for which data are available represent 95 per cent of bed capacity of the State.

f/ Figures are based on data for all general hospitals, maternity homes, etc. in the State.

g/ The average hospital stay for all residents is approximately 3 days longer in New York City than in the rest of the State. For Blue Cross participants, the longer average hospital stay in New York City is less marked.

equalize expense. However, premiums are not graded in accordance with ability to pay.^{32/}

2. The enrollment of persons outside of groups based upon employment, etc., must be restricted because such persons tend to enroll primarily in anticipation of utilization of hospital service.
3. The enrollment of a disproportionate number of persons whose previous or present health status predisposes to hospitalization must be guarded against because of their high rate of utilization of hospital service.
4. Benefits such as radiology and anesthesia, which are traditionally a part of hospital service, are often not included and usually are limited when they are included.
5. A single contract covering physicians' services in the hospital as well as hospital service itself is not available.
6. As a rule, patients who have hospitalization insurance must engage a private physician and pay a fee, which is often not necessary in the case of uninsured persons engaging the same hospital service.

There is a strong demand on the part of the public for the kind of security afforded by hospitalization insurance, but the deficiencies noted would seem to present an insuperable obstacle to coverage of a substantial majority of the population unless some means is devised for overcoming them.

^{32/} It seems pertinent to observe here that there is a need for grading premiums in accordance with ability to pay, at least roughly so. While it is true that such grading does not and need not apply to the purchase of ordinary commodities, it is equally true that the self-supporting person or family can obtain such commodities by the purchase of perhaps less satisfying but nevertheless adequate, inexpensive varieties consistent with income. On the other hand, there is not, or should not be, such a thing as an inexpensive variety of hospital service, except for the accommodations. The whole system of variable medical and hospital costs is based primarily upon the patient's ability or inability to pay, persons of above average income paying in excess of the actual cost in order to permit persons of less-than-average income to receive care at less than actual cost (supplemented in some instances by charitable contributions.) See Table 15, Chapter III.

This laudable principle is not carried over into the field of hospitalization insurance simply for the reason that enrollment in an insurance plan being voluntary, many persons who would be entitled to premiums of less than average cost would join, whereas few persons of better than average means would join knowing that they would have to pay more than the average insurance rate. The same degree of volition is not afforded to the person of above-average income who enters a hospital, first because he usually has no choice but to enter the hospital and submit to its rules, and second because he is often unaware that a part of the amount he must pay is used to defray the costs for persons who cannot pay the full amount.

CHAPTER XII

NON-PROFIT MEDICAL CARE INSURANCE

Types of Medical Care Insurance

The term medical care insurance, or medical expense insurance is reserved for insurance against the expense of physicians' services, and often x-ray and laboratory diagnostic services also. It does not include hospital service. A very great majority of medical care insurance plans in New York State fall into one of the three following groups:

Non-profit medical expense indemnity corporations organized under the Membership Corporations Law or the Cooperative Corporations Law, and coming under the supervision of the State Department of Insurance pursuant to the provisions of Article 9-C of the State Insurance Law.

Unions and associations of employees which qualify as exempt organizations under Section 456 of the State Insurance Law, and which provide benefits to their members without being licensed by the State Department of Insurance.

Group health and accident policies issued by licensed insurance companies. A group health and accident policy may be issued to an employer or to the trustee of a fund established by the employer members of a trade association and maintained by contributions of employers for the sole benefit of contributing employers. This type of policy may also be issued to or in the name of an incorporated or unincorporated association of employees. Certain types of group policies provide hospital and medical expense indemnity benefits in addition to cash sickness benefits.

In addition to these three types, personal medical care insurance policies may be purchased by individuals, but the number of such policies is negligible. There are other types of group protection against the costs of medical care which fall under the general heading of prepayment medical care without partaking of the nature of insurance, e.g., the Endicott-Johnson plan where the employer pays the complete cost.

There are, exclusive of group and personal health and accident policies, 30 prepayment medical care plans of all types in New York State. Table 1 gives the name, type and membership of 28 plans listed in Prepayment Medical Care Organizations,^{1/} and two others subsequently organized.

A summary of the total persons eligible for care, by type of plan, is 1/ Prepayment Medical Care Organizations, Margaret C. Klem. Bureau Memorandum No. 55, Social Security Board, Bureau of Research and Statistics, 3rd edition, June 1945.

Table 1. Prepayment Medical Care Organizations, New York State.

Name and address	Type of organization	1945 membership
1. The Pension and Benefit Department, F. C. Huyck and Sons, Kenwood Mills, Albany	Industrial	810
2. Mutual Benefit Association, Binghamton Die and Machine Co., Binghamton	Industrial <u>a/</u>	34
3. The Mutual Benefit Association, Dunn and McCarthy, Inc., Binghamton	Industrial <u>a/</u>	1,114 <u>b/</u>
4. Agfa Ansco Mutual Benefit Association, General Aniline and Film Corp. (including Ozalid Products Division), Binghamton	Industrial <u>a/</u>	5,155 <u>b/</u>
5. Spaulding Employees' Mutual Benefit Association, Spaulding Bakeries, Inc., Binghamton	Industrial	491 <u>b/</u>
6. Employees' Aid Society, Eberhard Faber Pencil Co., Brooklyn	Industrial	639
7. Mergenthaler Mutual Aid Society, Mergenthaler Linotype Co., Brooklyn	Industrial	525
8. New York Medical Service Co., Brooklyn	Private group clinic	5,700 (families)
9. Western New York Medical Plan, Inc., Buffalo	Medical society <u>a/</u>	31,681 <u>b/</u>
10. Workers Medical and Relief Department, Endicott-Johnson Corporation, Johnson City	Industrial	42,000 <u>b/</u>
11. Medical Plan, Cafeteria Employees Union, Local 302, New York	Consumer-sponsored	11,700 <u>b/</u>
12. Consolidated Edison Employees Mutual Aid Society, Inc., Brooklyn Edison Employees' Mutual Aid Society, Association of Employees of the New York and Queens Electric Light and Power Co., New York	Industrial	20,000
13. Group Health Cooperative, Inc., New York	Consumer-sponsored <u>a/</u>	9,352 <u>b/</u>
14. International Ladies Garment Workers Union, New York (Locals 91 and 62; 22, 60 and 89; 38, 40 and 132; 23, 25, 66 and 105; 32, 64 and 155; and 35, 102 and 117)	Consumer-sponsored	131,049
20. International Workers Order, New York City Central Committee, New York	Consumer-sponsored	67,000 <u>b/</u>
21. Kops Brothers Employees Mutual Aid Association, Kops Brothers, Inc., New York	Industrial	400
22. Macy Mutual Aid Association, R. H. Macy and Co., New York	Industrial	7,439
23. Medical Care Plan, New York Stock Exchange, New York	Industrial	1,000
24. Solvay Mutual Benefit Society, The Solvay Process Co., Semet-Solvay Co., Solvay Sales Corp., Syracuse	Industrial <u>a/</u>	-
25. Sick Benefit Fund, Syracuse Chilled Plow Co., Inc., Syracuse	Industrial	235
26. Medical and Surgical Care, Inc., Utica	Medical society <u>a/</u>	33,136 <u>b/</u>
27. United Medical Service, New York	Medical society <u>a/</u>	102,853 <u>b/</u>
28. Central New York Medical Plan, Inc., Syracuse	Medical society <u>a/</u>	2,036 <u>b/</u>
29. Health Insurance Plan of Greater New York, Inc.	Public group <u>a/</u>	<u>c/</u> <u>b/</u>
30. Genesee Valley Medical Care Inc., Rochester	Medical society <u>a/</u>	<u>c/</u> <u>b/</u>

a/ Service provided by physicians of the communities served; in other plans, service is provided by panel or salaried physicians.

b/ Covers both subscribers and dependents; others cover subscriber only.

c/ Not yet in operation.

presented in Table 2.

Table 2. Number and Type of Prepayment Medical Care Organizations, and Number of Persons Eligible for Care, New York State, April-June, 1945^{1/2/}

Type of organization	Number ^{a/}	Persons eligible for care		
		Subscribers	Dependents	Total
Industrial	14	49,596	30,246	79,842
Medical society	5	88,672	84,653	173,325
Private group clinic	1	5,700	11,400	17,100
Consumer-sponsored	9	159,499	59,602	219,101
Public group	1	--	--	--
Total	30	303,467	185,901	489,368

^{a/} One medical society and one public group not yet in operation; membership data not available for one industrial plan.

This study is limited to plans which are open to membership by the general public, thus excluding the industrial and a majority of the consumer-sponsored plans. The plans studied all come under the heading of non-profit medical expense indemnity corporations, and are those listed in Table 3.^{3/}

Table 3. Enrollment in Non-Profit Medical Care Plans, July 1, 1945.

Plan	Principal city in area covered	Date established	Number of subscribers	Total participants
Group Health Cooperative	New York	1939	9,250 ^{a/}	14,000 ^{a/}
United Medical Service	New York	1944 ^{b/}	72,243 ^{b/}	129,573 ^{b/}
Plan 1	"	-	-	119,834
Plan 2	"	-	-	2,047
Plan 3	"	-	-	5,797
Plan 4	"	1945	-	-
Health Insurance Plan of Greater New York	New York	1944 ^{c/}	0	0
Medical and Surgical Care, Inc.	Utica	1939	18,154	36,321
With medical call rider	"	-	-	7,624
Central N.Y. Medical Plan	Syracuse	1945	872	2,036
Western N.Y. Medical Plan	Buffalo	1939	19,095	48,577
Genesee Valley Medical Care Plan	Rochester	1945 ^{c/}	0	0
Total			119,614	230,507

^{a/} Estimated.

^{b/} When United Medical Service was formed in May 1944, as a merger of Medical Expense Indemnity and Community Medical Care, which had been in operation for several years, 1,147 participants of the former elected to maintain the contract they had been carrying. However, this contract is not being sold to the general public. Community Medical Care had a ward contract, the sale of which was discontinued at the time of the merger, but 748 are still in effect.

^{c/} Not yet in operation.

^{2/} Includes data from studies made by Commission on Medical Care.

^{3/} The various plans upstate are referred to herein by the name of the principal city in the area covered by the plan. Thus, "the Buffalo plan" or "the Buffalo area" refers to the plan and entire area covered by the Western New York Medical Care Plan, Inc.

The membership figures given in Table 3 were furnished by the plans themselves, and are somewhat higher than those in Table 1, owing to the inclusion of additional plans and some growth in membership in the first 6 months of 1945. The areas covered or to be covered by these plans are shown in Figure 1.^{4/} In addition to the plans listed, the New York State High School Athletic Association, which limits its function to insuring students participating in school athletics, covers the entire State. The Albany area will soon be served by a plan being organized by the Albany County Medical Society.

Legal Aspects

If a plan is to be organized under the Membership Corporations Law, the consent of the State Department of Social Welfare must be obtained. Whether organized under this law, or under Article 7 of the Cooperative Corporations Law, a license must be obtained from the State Superintendent of Insurance and the operation of the plan must conform to the State Insurance Law. The latter terms these plans "non-profit medical expense indemnity corporations" and defines medical expense indemnity as "reimbursement for medical care provided through duly licensed physicians, for nursing service and for furnishing necessary appliances, drugs, medicines and supplies."^{5/}

The State Insurance Law also provides that the plans must be open to the participation of all duly licensed physicians, thus precluding the organization of selected groups of physicians to offer medical insurance to subscribers.^{6/} Medical expense indemnity and hospital service corporations may join in issuing a combined contract including both hospital and medical service, but neither of such corporations may alone issue a contract covering both types of benefits. Not more than 18 counties may be covered by any plan except the New York State High School Athletic Association.

^{4/} The areas shown in Figure 1 are those for which charters have been issued by the State. However, plans are not operative in all of these counties. There is no active recruiting in Niagara and Chautauqua Counties. The Genesee Valley Medical Care Plan and Health Insurance Plan of Greater New York have not yet begun operations.

^{5/} The language of the law suggests that the insurance organization be required to make payment to the insured rather than to the physician or other person furnishing service. Although the contracts of several plans are so worded as to permit this method of payment, in practice payment is made directly to the person furnishing service. Supposedly, the patient is indirectly indemnified for expenditures he has independently incurred.

^{6/} These plans differ in this respect from the industrial and consumer-sponsored plans, which qualify as exempt organizations, being unions or associations of employees.

Contracts and rates must be approved by the State Superintendent of Insurance. Contracts may cover either one person, a husband and wife, or husband, wife, and children under 13 years of age. Substantial reserves are required. Not more than 10 per cent of income may be used for soliciting subscribers, and not more than 20 per cent for additional administrative expenses. Solicitors may not be paid on a commission basis. Organizations which meet these requirements are exempt from all State, county and municipal taxes.

General Characteristics

As a rule, the medical plans have been organized by or in cooperation with county medical societies. The Medical Society of the State of New York has approved most of the plans currently in operation, the principal criteria being adequate representation of the organized medical profession in the direction and operation of the plan, and approval by the local medical society of the terms and provisions of the plan.^{7/} The State Medical Society has become very much interested in the promotion of these plans, and has created a Bureau of Medical Care Plans to aid and advise in their development and extension.

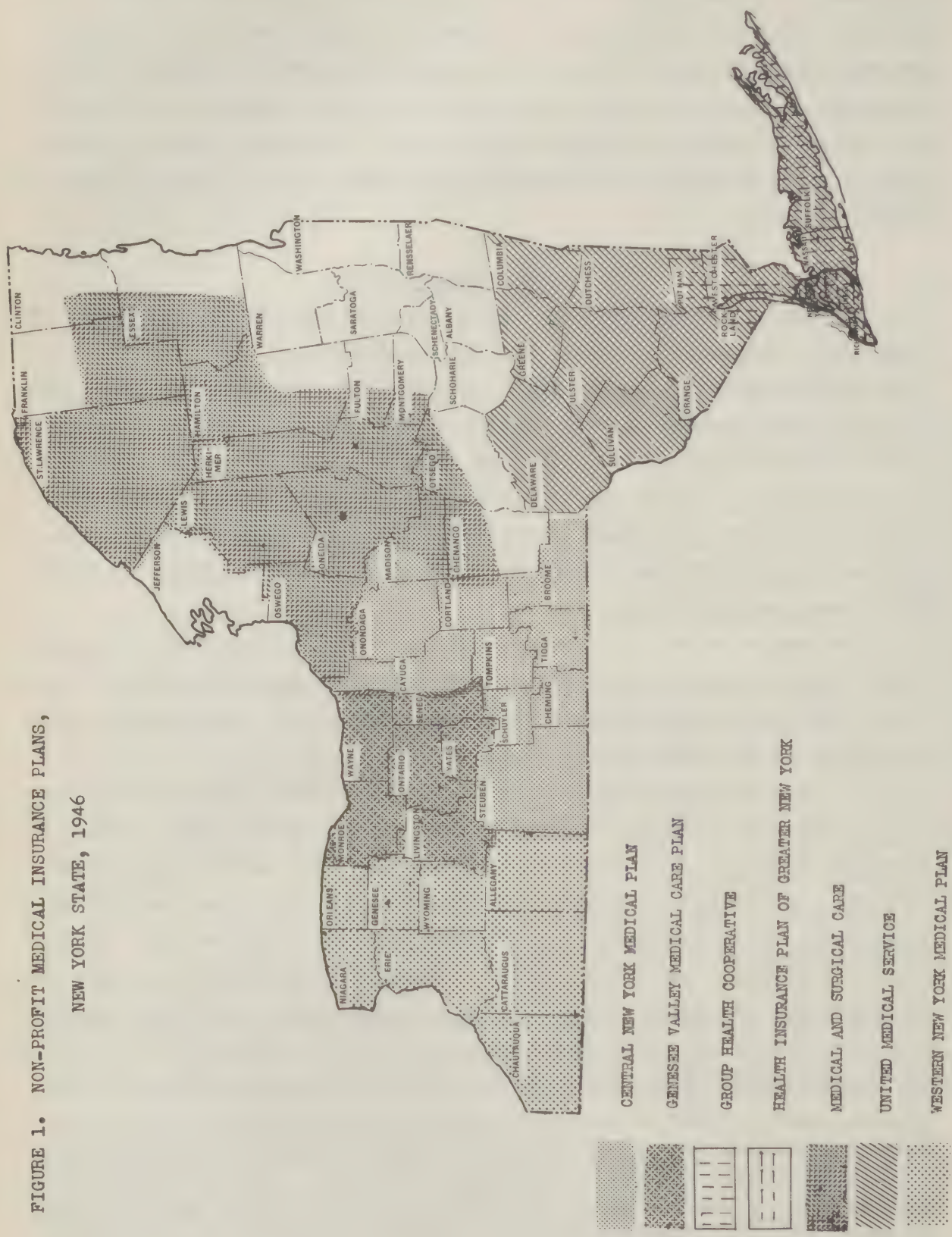
The medical care plans are governed by boards of directors. Although there is no legislative provision concerning the composition of such boards, the by-laws of the corporations, with one exception,^{8/} have specified that a majority of the members must be physicians.

Any licensed physician may join the panel of "participating physicians", i.e., physicians who agree to furnish the care called for under the subscriber's contract. Fee schedules are generally established by the board of directors after consultation with physicians in the area. Most of the schedules closely follow that established under the New York State Workmen's Compensation Law. Fees paid to non-participating physicians are generally lower than those paid participating physicians. Participating physicians agree to accept pro-rated payments (without recourse to the patient for the remainder of the scheduled fee) when the financial status of the plan prevents payment in full. In plans providing benefits on a service

^{7/} Statement by Mr. George P. Farrell, Director, Bureau of Medical Care Insurance, Medical Society of the State of New York. No official statement by the Society has been forthcoming. However, it has been indicated by other sources that there are other criteria for approval, for example, that benefits should not be provided on a service basis to families with incomes over \$2,500.

^{8/} Only one-third of the members of the Board of the Health Insurance Plan of Greater New York are physicians, but matters of professional concern rather than of public concern are handled by a Medical Control Board composed of physicians.

FIGURE 1. NON-PROFIT MEDICAL INSURANCE PLANS,
NEW YORK STATE, 1946



basis, participating physicians agree not to charge in excess of the scheduled fee in the case of persons with incomes under a fixed limit. Under the indemnity plans, the physician may charge in excess of the scheduled fee. Often, plans combine the service and indemnity features so that charges in excess of the fee schedule may be reviewed by a physicians' committee if the subscriber claims that he is below a specified income limit and is entitled to service at no extra charge.

The contract for participating physicians sets forth certain standards of professional conduct which, if violated, may be the basis for removal from the panel of participating physicians. This and the pressure of opinion which the county medical society and other participating physicians may bring to bear on physicians who abuse the plan, constitute the disciplinary action.

Medical care insurance on a non-profit basis is newer than similar plans for hospitalization insurance through Blue Cross plans. The development of medical care plans has been facilitated by Blue Cross plans, which have conducted the business affairs of the present medical plans (with the exception of Group Health Cooperative)^{9/} and have made possible economies of operation for the new organization through joint administration for selling, billing, records and payments. In fact, membership in several medical care plans is contingent on membership in a Blue Cross plan.

Medical care insurance seems to be much more difficult to sell than hospitalization insurance because, as a rule, the cost must be added to the premium for hospitalization insurance. Also, the cost of anything approaching comprehensive coverage is high (see Table 4). Although more than 20 per cent of the residents of New York State are covered by hospitalization insurance, less than 2 per cent are covered by the non-profit medical care insurance plans. At a conference of representatives of the voluntary non-profit plans and representatives of the Commission, the chief suggestion offered by the former for increasing enrollment through State action was to amend the State Insurance Law to permit a single contract to be issued by a single corporation.^{10/}

^{9/} It is believed that the Health Insurance Plan of Greater New York will be operated independently.

^{10/} However, not all plan executives subscribe to this view, and one executive suggested that medical care insurance did not sell as well as hospitalization insurance because financial need is not as great and as unexpected. The State law now permits a contract covering both medical and hospital services to be issued jointly by hospital and medical plans, although such a contract may not be issued by either plan singly. To date, no joint contracts have been issued. The Health Insurance Plan of Greater New York is contemplating issuing such a contract in conjunction with Associated Hospital Service of New York.

Table 4. Annual Premiums Charged by Non-Profit Medical Care Plans in New York State.

Name of plan and type of contract	Area	Annual premium					
		Group			Individual		
		Payroll deduction		Direct payment			
		Single	2 person	Single	2 person	Family	2 person
United Medical Service	N.Y. City						
1. Surgical indemnity		\$ 4.80	\$12.00	\$6.00 f/	\$15.00 f/	\$25.00 f/	\$6.00 f/
2. Surgical service		6.24	13.44	g/	g/	g/	-
3. Surgical medical service		7.68	16.32	g/	g/	g/	-
4. Experimental (comprehensive)		19.20	-	-	-	-	-
Group Health Coop.	N.Y. City						
Surgical-medical		9.60	19.20	10.40 e/f/	20.80a/f/	26.40 a/f/	-
Health Insurance Plan	N.Y. City						
Comprehensive		i/	i/	i/	i/	i/	-
Central N. Y. Med. Plan	Syracuse						
Surgical		7.20	-	g/	g/	g/	-
Surgical with medical rider		18.00	-	g/	g/	g/	-
Western N. Y. Med. Plan	Buffalo						
Surgical		7.20	-	h/	h/	h/	- 1/
Surgical with medical rider		18.00	-	h/	h/	h/	-
Medical and Surgical Care, Inc.	Utica						
Low cost surgical		5.76	11.88	-	-	-	-
Regular surgical		9.00	18.00	9.00	18.00	22.80 b/d/	18.00 k/
Medical rider		4.80	9.00	4.80	9.00	12.00 b/e/	9.00 k/
Genesee Valley Medical Care Plan	Rochester						
Surgical		7.20	-	g/	g/	g/	-

a/ Includes group conversion and persons transferring from old contract only.

b/ Includes dependents under 16.

c/ Dependents 16-18 and sponsored subscribers, \$6.12 each.

d/ Dependents 16-18 and sponsored subscribers, \$9.00 each.

e/ Dependents 16-18 and sponsored subscribers, \$4.20 each.

f/ No maternity benefits.

g/ Persons leaving groups, billed directly at group rate for remainder of contract year, then at a conversion rate not yet set up.

h/ Persons leaving groups billed quarterly or annually, with a \$.10 added charge per billing.

i/ Approximately 4 per cent of first \$5000 of income.

j/ Rate not yet determined.

k/ In addition there is an enrollment fee for individually enrolled subscribers.

l/ To be offered in February 1946 at \$9.60 for single person and \$24.00 for family.

Note: Maternity benefits are included on all family contracts after a waiting period, with the exception of non-group subscriber contracts of United Medical Care Plan 1 and of Group Health Cooperative.

Many plans encourage employers to participate in paying employees' premiums. Nearly all of the employers of groups subscribing to Group Health Cooperative contribute part or all of the premium. Employer contribution is essential if a plan requires, as a number do, that at least 75 per cent (or more for small groups) of the employees in a group maintain membership in the plan, because the low-income employees (or those with heavy family responsibilities) might find it impossible to pay the premium unaided. Many plans report that employers are more willing to contribute toward medical care insurance premiums than toward hospitalization insurance premiums.

Whereas the Blue Cross plans are service plans, ^{11/} the medical care plans are generally indemnity plans. Group Health Cooperative and United Medical Service provide service benefits on certain contracts, but only for persons whose income is below specified limits.

In examining the benefit provisions of the medical care plans, it is important to keep in mind the benefits offered by the area's Blue Cross plan, since the former does not duplicate Blue Cross benefits. Medical care plans in all instances provide group subscribers with in-hospital surgical and obstetrical care, and several plans include these as out-of-hospital benefits, also.^{12/} A waiting period of 6 to 12 months may be required in the case of obstetrics, and such surgical procedures as tonsillectomy, herniorrhaphy, etc.

X-rays, laboratory tests, electrocardiograms, etc., in or out of the hospital or elsewhere are sometimes included if they are not provided by the local Blue Cross plan. Where physicians' services out-of-hospital are available, the subscriber usually has the choice of a surgical contract without out-of-hospital services, or a contract which provides both surgical and medical benefits, or a "medical call rider" to supplement the surgical contract.

Surgical and obstetrical benefits are the simplest of these benefits to administer and are the least subject to apparent misuse. For this reason, a majority of plans permit out-of-hospital as well as in-hospital surgical and obstetrical care. Medical service, and x-ray and laboratory tests are more difficult to control outside of a hospital. In the Utica area, for example, it was necessary to discontinue out-of-hospital x-ray

^{11/} Maternity and private accommodations and benefits in non-member hospitals are on an indemnity basis generally.

^{12/} Non-group subscribers in United Medical Service and Group Health Cooperative do not receive obstetrical care.

and laboratory benefits because of excessive use by certain physicians with equipment in their offices. In-hospital x-ray and laboratory benefits were used more moderately because the prescribing physician did not profit by providing such services.

Other benefits which may be included are specialist's consultation, visiting nursing service in the home, and physicians' calls at hospital, home and office. Group Health Cooperative is the only plan to provide visiting nursing service in the home.

Experiments with contracts including physicians' home and office calls, such as are now available in the Buffalo and Syracuse areas, have not always been successful. The Medical Expense Fund of New York (now part of United Medical Service), Group Health Cooperative, and the Utica plan issued this type of contract at one time. These were found to be financially unsound, particularly in coverage of non-group subscribers. As a result, these contracts are no longer issued.

The Buffalo plan formerly issued a service contract providing very comprehensive benefits. The demands on the plan were so much in excess of the amount anticipated, and the premiums, that it was necessary to pro-rate payments to physicians at the rate of 75 per cent of scheduled fees. In preference to increasing premiums, the benefits were curtailed and the indemnity system adopted. In commenting on the original service contract, Dr. Carlton E. Wertz, president of the Buffalo plan, made the following observations:^{13/}

Our first (major) error was taking the principle of providing complete care too literally. In our original contract we provided for just about every medical service that could be imagined and we did so without sufficient recognition of the human element. Consequently adequate controls against abuse were not established. Furthermore we attempted to categorically establish benefits on a basis of varying economic levels.

We soon found that we could neither ignore the human shortcomings nor the inherent principle of American freedom of action. The necessity of providing confidential information regarding incomes was resented by the employee and the employer.

Our second error occurred in not taking seriously the importance of simplicity in administrative operations. We had attempted to control some abuse of home and office calls for minor, non-surgical ailments by what we called co-insurance. This provided that both the corporation and the subscriber would each stand half of the expense for such service up to a certain amount. This was administratively impractical, causing confusion to both the doctor and the patient and did not accomplish in any event its purpose.

^{13/} "A Practical Prepayment Medical Plan," C.E. Wertz, Hospitals, 17:53, June 1943.

Unemployed married women appear to be relatively poor risks. As a result, several plans limit benefits for such women to the benefits available to dependents, even though the woman is in fact a subscriber. Further, no married woman living with her husband may subscribe unless her husband is also covered by the contract.

The plans exclude care of cases covered by Workmen's Compensation, cases treated in veterans hospitals, and those for whom care is provided through Federal or State laws, e.g., mental cases and tuberculosis. Most of the plans exclude care of venereal disease, drug addiction and alcoholism; however, in practice such cases are frequently covered since the obvious signs or symptoms may be differently diagnosed. The treatment of pre-existing conditions, congenital anomalies and cases requiring plastic surgery is either excluded, or provided only after a waiting period. None of the existing contracts cover drugs or appliances, nursing fees,^{14/} blood donor service, preventive immunizations or eye refractions.

Income and Expenditures

The financial operations of the plans in 1944 are indicated in Table 5.

Table 5. Income and Expenditures of Selected Medical Care Plans, 1944.^{a/}

Item	Buffalo plan	United Medical Service	Utica plan
Income			
Premiums	\$279,632.71	\$324,661.62	\$187,024.77
Other	681.46	0	621.34
Expenditures			
Medical care	242,798.56	174,030.63	116,855.09
Administration	29,724.61		16,535.57
Promotion	3,836.95	(50,986.04)	10,163.56
Other	0		1,267.81

^{a/} Group Health Cooperative omitted, because 1944 is not a representative year.

Table 6 shows, for the plans for which comparable data were available, the per capita payment to physicians for the various services provided. Although none of the contracts are strictly comparable, it appears that for groups of persons such as these, in-hospital surgical service may be provided for about \$3.30 per person and surgical service in-and-out of hospital for about \$3.70. Surgical and medical in-hospital service may be as low as \$3.60. The cost rises to \$9.25 if limited medical service is provided out-of-hospital.

Because the New York State plans have changed benefit provisions frequently, it has not been possible to depict cost trends over a period of years. However, Table 7 illustrates a phenomenon common to all voluntary plans - a rather high per capita cost for physicians' services originally,^{14/} Except visiting nurse service provided by Group Health Cooperative.

Table 6. Annual Average Expenditure per Participant for Services Provided by Physicians under Medical Care Plans.

Type of contract ^{a/}	Average no. of participants	Payments to physicians	Average per participant
United Medical Service - 1945 ^{b/}			
Surgical indemnity	126,043		
Surgical service	2,194	\$112,537 ^{c/}	\$3.31 ^{c/}
Surgical - medical, in hospital	7,671		
Group Health Cooperative, 1944			
Surgical - medical, in hospital	7,178	26,012	3.62
Western New York (Buffalo), 1944			
Surgical only	5,416	20,035	3.70
Single person	1,365	4,773	3.50
Husband - wife	488	1,422	2.91
Family (incl. obstetrics)	3,563	13,840	3.88
Surgical - medical, in and out of hospital	24,078	222,763	9.25
Single person	2,870	26,825	9.35
Husband - wife	621	6,804	10.96
Family (incl. obstetrics)	20,587	189,134	9.19

a/ Refer to Table 7 for detailed benefit provisions.

b/ For third quarter of 1945 only; average per participant has been adjusted to an annual basis.

c/ For all contracts combined.

Table 7. Annual Average Expenditure per Participant for Surgical Services Provided by Physicians, Michigan Medical Service

Year	Average per participant ^{a/}
1940	\$8.75
1941	6.39
1942	6.06
1943	5.61
1944	5.44

a/ May differ from costs in Table 6 because of differing benefit provisions and fees.

due to surgical correction of accumulated disabilities, and a decline as this need has been met.

Eligibility and Benefits

The provisions relating to eligibility for enrollment and benefits have been summarized in Tables 8 and 9. No two plans offer identical service, at the same rates, to the same segments of the public. Although the Rochester and Syracuse plans were modeled after the Buffalo

plan, they contain some variations from the latter. For this reason, the various plans are described in some detail in the following pages.

Group Health Cooperative

This plan is a consumers' and producers cooperative which started operations in 1939, offering a comprehensive medical-surgical service plan to group and non-group subscribers below certain income limits.^{15/} It provided general practitioner service in the home, office or hospital,

^{15/}With the approval of the Economics Committees of the five county medical societies in New York City, and the approval of a number of individual societies, including New York, Queens and Westchester counties.

specialist service, surgical and maternity care, the latter for group subscribers only (with a \$25 charge to patient). Premiums were fixed at \$18 per person for group subscribers, and \$24 for subscriber and \$18 for each dependent for non-group subscribers. This plan was discontinued in 1943 since it did not prove financially sound, the distribution of risks being bad and the use of service excessive in terms of premiums charged and fee-for-service basis of payment to physicians.

As a result of this experience, a more limited plan for surgical and obstetrical benefits in home, office and hospital, and medical care in hospital only is now offered. Only group enrollment (ordinarily with the employer contributing toward the premium) is accepted. Subscriptions are not accepted unless the minimum proportion of the group enrolled is 100 per cent for groups numbering 5-24, 90 per cent for groups numbering 25-49, and 75 per cent for groups numbering 50 or more. This proportion must be maintained after initial enrollment. (Maintenance of membership after leaving the group is permitted if the subscriber is under 65 years of age; however, no maternity benefits are available on such contracts.) The contract is offered on a complete service basis to individuals with annual incomes under \$1,800, two persons with incomes under \$2,500, and families with incomes under \$3,000. Persons with incomes in excess of these limits are furnished care on an indemnity basis.

Enrollment is open to persons up to 65 years of age. Dependent children under 18 may be covered under a family contract; when these children reach 18 they may be covered under individual contracts. Infants born into the plan become eligible at one month, other infants are eligible at 90 days.

Benefits include medical practitioner services in hospital for 21 days in any one year; ^{16/} surgical services in hospital, home or office; obstetrical service (not including prenatal care) in home or hospital; one specialist consultation (\$10 fee) for each hospitalized illness; and visiting nurse service in illnesses covered by the contract. A waiting period is required for obstetrics, tonsillectomy, and treatment of pre-existing conditions. Treatment of communicable or venereal disease, drug and alcohol addiction, nervous and mental disorders, correction of congenital anomalies, and cosmetic or plastic surgery necessitated by pre-existing conditions are not

^{16/} Maximum rate of indemnity payments to physicians for in-hospital medical care is \$10 the first day, \$5 per day for the second through the fifth day, and \$4 per day for the sixth through the twenty-first day.

Table 8. Benefit Provisions of Non-Profit Medical Care Plans in New York State.

	New York City area					Rochester area	
	Group Health Cooperative	United Medical Service				Health Insurance Plan, Greater N.Y.	Genesee Valley Medical Plan
		Surgical Indemnity (1)	Surgical Service (2)	Surgical Medical Service (3)	Experimental comprehensive plan (4)		
IN-HOSPITAL							
Medical	Yes <u>a/</u>	No	No	Yes <u>g/</u>	Yes	Yes	No
Surgical	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Limit per illness	<u>b/</u>	<u>e/</u>	<u>f/</u>	<u>f/</u>	<u>f/</u>	None	\$150 <u>r/</u>
Obstetrical <u>u/</u>	Yes <u>c/</u>	Yes <u>c/</u>	Yes	Yes	Yes	Yes	Yes
Spec. consultation	Yes <u>d/</u>	No	No	No	Yes	Yes	No
Other					<u>v/</u>	<u>w/</u>	<u>o/</u>
OUT-OF-HOSPITAL							
Medical	No	No	No	No	Yes	Yes	No
Surgical	Yes	No	No	No	Yes	Yes	Yes
Obstetrical	Yes <u>c/</u>	No	No	No	Yes	Yes	Yes
Home visiting nurse	Yes	No	No	No	No	Yes	No
Spec. consultation	No	No	No	No	Yes	Yes	No
Other					<u>v/</u>	<u>w/</u>	<u>o/</u>

	Utica area			Syracuse area		Buffalo area	
	Medical and Surgical Care			Central N. Y. Medical Plan		Western N. Y. Medical Plan	
	Low-price Surgical	Regular Surgical	Medical Call Rider	Surgical	Medical Rider	Surgical	Medical Rider
IN-HOSPITAL							
Medical	No	No	Yes <u>n/</u>	No	Yes <u>p/</u>	No	Yes <u>p/</u>
Surgical	Yes <u>i/ j/</u>	Yes <u>l/ j/</u>	-	Yes	-	Yes	-
Limit per illness	1 <u>Proced.</u>	1 <u>Proced.</u>	-	\$150 <u>r/</u>	-	\$150 <u>r/</u>	-
Obstetrical <u>u/</u>	Yes <u>s/</u>	Yes <u>t/</u>	-	Yes	-	Yes	-
Spec. consultation	No	No	-	No	Yes <u>q/</u>	No	Yes <u>q/</u>
Other	<u>h/</u>	<u>k/</u>	-	<u>o/</u>	<u>q/</u>	<u>o/</u>	<u>q/</u>
OUT-OF-HOSPITAL							
Medical	No	No	Yes <u>n/</u>	No	Yes <u>p/</u>	No	Yes <u>p/</u>
Surgical	Yes <u>i/ j/</u>	Yes <u>l/ l/</u>	-	Yes	-	Yes	-
Obstetrical <u>u/</u>	Yes <u>s/</u>	Yes <u>t/</u>	-	Yes	-	Yes	-
Home visiting nurse	No	No	No	No	No	No	No
Spec. consultation	No	No	No	No	Yes <u>q/</u>	No	Yes <u>q/</u>
Other		<u>m/</u>		<u>o/</u>	<u>q/</u>	<u>o/</u>	<u>q/</u>

a/ 21 days per year.

b/ For 2 or more procedures at the same time, allows the greater plus 1/2 the lesser one.

c/ For group subscribers only.

d/ One per hospitalized illness, \$10 fee.

e/ For 2 or more procedures at the same time only the more expensive one allowed; for more than one operation for the same cause within three months, \$150 maximum.

f/ For 2 or more procedures at the same time, the primary one reimbursed.

g/ After 3rd day hospitalization; partial coverage from 21st to 111th day \$5 basal metabolism, electrocardiogram and laboratory.

h/ For subscriber and each dependent per year: \$10 anesthesia; \$5 x-ray; \$5 basal metabolism, electrocardiogram and laboratory.

i/ Limit per year all benefits: \$200 for subscriber, \$100 any one dependent, \$325 any 3 or more persons.

j/ Dependents receive 1/2 surgical fees as scheduled.

k/ For subscriber and each dependent per year; \$10 anesthesia; \$10 x-ray; \$5 basal metabolism; \$5 electrocardiogram; \$7 laboratory, \$5 sutures @ \$1.00 each.

l/ Limit per year all benefits: \$225 for subscriber, \$125 any one dependent and \$350 for 3 or more persons.

m/ \$5 for suture @ \$1.00 each.

Table 8, continued.

n/ \$2 hospital calls, and \$3 house and \$2 office calls, to the extent of: 3 house or office calls only within 10 days of hospital discharge; 1 call per day; 21 per hospitalized illness; 4 calls a week for contagious diseases; and 48 calls for subscriber and each dependent not to exceed 150 per year.

o/ \$10 anesthesia per illness (excluding maternity), \$15 annually for diagnostic x-ray for surgical cases.

p/ \$2 hospital and office calls, \$3 other calls, maximum of 1 hospital call per day; 25 calls to subscriber and 15 to any dependent per year; no call for after-care for 60 days after surgical procedure except for medical complications. (After-care included in surgical fee schedule).

q/ For any one disability, \$5 endoscopic examination and \$5 specialist consultation, and annually \$10 (additional to surgical plan) diagnostic x-ray, \$10 therapeutic x-ray, \$5 each electrocardiogram (\$15 maximum), \$10 laboratory service (basal metabolism alone \$5), \$10 allergy tests, \$10 physiotherapy.

r/ Two or more procedures at same time, major one only; two or more procedures in one disability, \$150 maximum.

s/ Maximum annual allowance of \$40 for prenatal, delivery and post-natal care.

t/ Maximum annual allowance of \$50 for prenatal, delivery and post-natal care, \$30 for miscarriage, \$75 for ectopic pregnancy, \$75 caesarian section and \$25 uterine curettage (D & C).

u/ Benefit given only on family contracts after a waiting period.

v/ Electrocardiogram, physiotherapy, pathology, radiology, anesthesiology, etc.

w/ Any other medical or hospital services required by the condition of the patient.

Table 9. Provisions Concerning Eligibility for Coverage by Non-Profit Medical Care Plans.

Name of plan		Age limits	Group affiliation	Income limit	Pre-entrance physical	Previous illness limits	Service benefits
United Medical Service							
Surgical indemnity	(1)	90 days-65 yrs ^{a/}	No	No	No	None	No
Surgical service	(2)	90 days-65 yrs ^{a/}	Yes	b/	No	None	b/
Surgical-medical service	(3)	90 days-65 yrs ^{a/}	Yes	b/	No	None	b/
Experimental plan (comprehensive)	(4)	90 days-f/	Yes	b/	No	None	b/g/
Health Insurance Plan							
Comprehensive		None	Yes	\$5000	No	None	Yes
Group Health Cooperative							
Surgical-medical		90 days-65 yrs ^{c/}	Yes	b/	No	None	b/
Central New York Medical Plan							
Surgical		90 days-65 yrs	Yes	No	No	Yes ^{d/}	No
Surgical with medical rider		90 days-65 yrs	Yes	No	No	Yes ^{d/}	No
Medical and Surgical Care (Utica)							
Low cost surgical		60 days-65 yrs	Yes	No	No	No	No
Regular surgical		60 days-65 yrs	No ^{e/}	No	No	No	No
Medical rider		60 days-65 yrs	No ^{e/}	No	No	No	No
Western New York Medical Plan							
Surgical		30 days-65 yrs ^{a/}	Yes	No	No	Yes ^{d/}	No
Medical rider		30 days-65 yrs ^{a/}	Yes	No	No	Yes ^{d/}	No
Genesee Valley Medical Care							
Surgical		90 days-65 yrs ^{a/}	Yes	No	No	Yes ^{d/}	No

a/ No limit to retain membership.

b/ Service benefits applicable within specified income limits. Over such limits, indemnity benefits given.

c/ Thirty days if born into plan. Membership may be retained while employed regardless of age.

d/ Persons having had cancer, diabetes, osteomyelitis, tuberculosis, chronic nephritis or coronary thrombosis are excluded.

e/ Those eligible to enroll through group must do so.

f/ As long as employment continues

g/ For specialist service, scheduled fee is shared by patient and plan.

included. Diagnostic x-ray and laboratory services are excluded.^{17/}

Visiting nurse service has recently been introduced on an experimental basis, service being rendered through the visiting nurse associations. All visits requested by the physician are provided in illnesses or other conditions covered by the contract. In metropolitan New York, the benefit is provided on a service basis, but in other areas it is rendered on an indemnity basis, with the patient reimbursed for payment made to the nursing agency.

Payroll deduction premiums are \$9.60 for an individual, \$19.20 for two persons, and \$24.00 for family. Direct payment premiums are \$10.40, \$20.80, and \$26.40 respectively. The plan has been able to maintain this premium, despite its relatively small size and the extensive research programs carried on, through the assistance of grants by the Rockefeller Foundation.

United Medical Service

Several medical care plans have operated in the New York metropolitan area over the past several years. United Medical Service was organized in 1944 as the result of a merger of Community Medical Care, Inc., and Medical Expense Fund of New York, Inc. An effort has been made to coordinate the 3 non-profit medical care plans in the area, but Group Health Cooperative did not join. United Medical Service is the organization in Greater New York which has been sponsored by the medical societies.

At present, United Medical Service offers Plan 1 - a surgical indemnity contract providing surgery and obstetrics in hospital; Plan 2 - a surgical service contract covering similar benefits (at physicians' fees similar to the Workmen's Compensation fee schedule) but providing full service for subscribers within certain income limits; Plan 3 - a surgical-medical service contract providing the same benefits as Plan 2, plus medical service in the hospital beginning with the fourth day; and Plan 4 - an experimental plan, recently inaugurated, providing comprehensive surgical, obstetrical and medical benefits. Enrollment in these plans is contingent on continued subscription to the Associated Hospital Service plan. Plan 1 has by far the largest number of persons enrolled. However, this is not an indication of comparative popularity since Plans 2 and 3 have only recently been offered to subscribers, and Plan 4 will enroll only a limited number of subscribers on an experimental basis.

^{17/} These are covered for in-hospital cases by the Blue Cross plan for the area.

Enrollment in Plans 2 and 3 is limited to employment groups. Subscribers for Plan 1 are enrolled on a group basis or, if unemployed, self-employed or employed in firms of less than 5 people, on an individual basis. For acceptance of a group for any of the three Plans, the minimum size of group is 5, of which 100 per cent must enroll; the minimum percentage enrollment is graded down to 40 per cent for groups of 500 or more. These percentages are applicable at time of enrollment only.

Service benefits under Plans 2 and 3 are limited to unmarried persons with incomes up to \$1,800, or married persons with incomes up to \$2,500. For persons with greater income, the participating physicians are permitted to charge in excess of the scheduled fees. If, however, family income is between \$2,500 and \$3,500, and the physician makes an additional charge to the patient, the patient may request the Physicians' Review Committee of the United Medical Service to review the case and determine the fee to be paid. The service benefits include after-care for varying periods, depending on the type of illness.

Benefits provided under Plans 1, 2 and 3 include an unlimited number of in-hospital operative or surgical procedures for treatment of disease and injury, treatment of fractures and dislocations, and in family contracts issued to group subscribers, maternity, prenatal and post-partum care. When two procedures are performed at the same time, payment is made for the one procedure which is the more expensive. The fees payable under Plan 2 are somewhat higher than under Plan 1. Plan 3 includes, in addition to the benefits of Plan 2, general medical care in the hospital after the 3rd day of hospitalization; after the 21st day only partial benefits are available.^{18/}

All contracts exclude cosmetic or plastic surgery for pre-existing conditions and congenital anomalies. Plan 3 excludes also medical service in any hospital admission primarily for diagnostic x-ray or laboratory examinations, other diagnostic studies, physical therapy, rest cures, mental disorders, pulmonary tuberculosis after diagnosis, and communicable diseases requiring isolation or quarantine. There is a waiting period of 6 months before benefits apply to tonsillectomy, 10 months for obstetrical care, and 11 months for the care of pre-existing conditions.

Annual premiums for payroll deduction groups are as follows. Surgical indemnity Plan 1 - individual \$4.80, husband and wife \$12.00, family \$21.80

^{18/} Maximum rate for indemnity payments to physicians for general medical care is \$3 per day for the 4th through the 21st day of each hospital admission and \$10 per week for the 22nd through the 111th day.

Surgical service Plan 2 - individual \$6.24, husband and wife \$13.44, family \$24.00. Surgical-medical service Plan 3 - individual \$7.58, husband and wife \$16.32, family \$28.32. Contracts for the surgical indemnity Plan 1, with individual underwriting, or group underwriting with individual billing, are billed quarterly or annually, at an annual rate for an individual of \$6.00, husband and wife \$15.00 and family \$25.00.

Plan 4 is in the nature of an experiment to ascertain the feasibility of providing comprehensive benefits. It is planned to enroll 25,000 members from groups throughout the area. Careful records will be kept on the experience in the use of benefits, cost, etc. Contracts are made with employers on behalf of those of their employees who have been employed for a minimum period of time and who will enroll within 30 days of reaching this eligibility date. Such persons must hold contracts for hospitalization insurance with Associated Hospital Service of New York. Dependents, including spouse and unmarried children 90 days to 18 years may be included at the time of enrollment, or at a later date, if the United Medical Service desires to accept them at that time. This United Medical Service option holds for coverage of dependents newly added to the family, unless they request inclusion under the contract within 30 days of joining the family. Coverage may be continued only for the duration of employment.

Premiums may be paid only through the employer. The annual premium rate is \$19.20 for an individual and \$48.00 for a family.

The plan provides limited service benefits to persons with individual contracts and incomes under \$1800 per year, and with family contracts and incomes under \$2500 per year. Families with incomes of \$2500 to \$3500 may request the Physicians' Review Committee for service rather than indemnity benefits.

Benefits included are: general medical care, surgery, maternity and specialists' care in home, office and hospital; for infants, only in-hospital care is provided. The contract does not include dentistry or refractions. Also excluded is care rendered by the medical department of an employer, medical examinations for physical checkups when not incident to treatment of illness, care of mental disorders, rest cures, alcoholism or drug addiction, cosmetic surgery, and congenital anomalies. Specialists' services must be approved by a practitioner prior to the service. If not so approved, only a general practitioner fee is allowed (even though specialist service has been given) and no allowance will be paid for tests (e.g., x-ray, electrocardiogram, etc.) by the specialist in such cases. Prior to allergy treatment, United Medical Service approval must be ob-

tained. Where there is no objective indication of illness, United Medical Service liability is limited to \$20.

The fee paid for general practitioner services is \$2 for office, and \$3 for home and hospital calls. (No additional payment for night calls is made by United Medical Service.) Authorization must be obtained from United Medical Service for all calls in excess of 1 per day and 20 per illness. Specialist service is on a co-insurance basis; i.e., the patient on a service basis contract is required to pay one-half of the scheduled fee, and the patient on an indemnity basis contract is required to pay one-half of the scheduled fee plus any additional charge made by the physician. The schedule for specialists' fees is \$10 for first visit in office or hospital; \$15 for first visit with electrocardiogram, or for home visit (limited to one such visit); \$3 per visit after the first; with electrocardiogram, \$5 per visit after the first. A detailed fee schedule is set up for surgery, neurology, psychiatry, pathology, radiology and anesthesiology. Participating physicians are reimbursed on the basis of the fee schedule. Non-participating physicians are reimbursed at a rate of 75 per cent of the fee schedule, and they are not bound to give any service benefits.

Health Insurance Plan of Greater New York

This plan was incorporated in 1944 with the purpose of making available all necessary medical service "to keep (the member) from getting sick and everything medically available to cure one who is sick."^{19/} No contracts have been issued to date, but the sponsors hope to begin operation of the plan sometime during 1946. Enrollment will be through groups of persons working or residing in New York. At first, only employment groups will be accepted, but it is expected that other types of groups will be enrolled shortly thereafter. To be eligible for enrollment, the subscriber's annual income must be under \$5000.

Benefits will be on a complete service basis and will include general practitioner at home, office or hospital, specialists' services, diagnostic x-ray and laboratory services, surgery, maternity and child care, preventive care, visiting nurse service, and all hospital service. It is anticipated that all physicians' services will be provided through medical groups organized for that purpose. Hospital benefits will be provided through arrangement with the Associated Hospital Service of New York.

^{19/} Mayor LaGuardia's Sunday Broadcast of April 30, 1944.

It was announced that premiums for employment groups, collected through payroll deduction, would be 4 per cent of earnings, at least one-half of which is contributed by the employer. It now appears, however, that premiums will be uniform in amount, regardless of income, and will be about \$48 per single person and \$96 per family. No extra payment will be required for dependents. It is proposed to make the plan available to the New York City employees as departmental groups at the start of operations, with the City paying one-half of the premium. No premium has been set as yet for groups which are not employment groups.

Western New York Medical Care Plan, Inc.

This plan pioneered in offering medical as well as surgical service. Further, its present contracts have served as models for the new Syracuse and Rochester area plans.

The original comprehensive contract, discontinued in 1942, was offered on a service basis to persons of limited income and on an indemnity basis to persons over such income limit, with a co-insurance clause whereby the subscriber shared the first \$20 of physicians fees with the Plan. This plan was not financially successful and payments to physicians were pro-rated at 75 per cent of par value for two years. Factors which may have entered into this situation are the difficulty in determining the subscriber's income, unwillingness of physicians to accept the scheduled fee as full payment, over-use of service, etc. Although continued until September 1, 1945 for persons previously subscribing,^{20/} this service contract is no longer offered to new subscribers. In its stead, there is offered an indemnity contract providing fairly comprehensive service.

Although the charter for this corporation covers 8 counties (see Figure 1), active solicitation of subscribers is not undertaken in Niagara and Chautauqua Counties. In the former county, the physicians are unwilling to cooperate. In the latter, the existence of another hospital service plan - the Chautauqua Region Hospital Service Corporation - poses administrative difficulties. Subscribers to the medical care plan who may live in Niagara or Chautauqua counties receive benefits on the same basis as do persons receiving benefits out-of-the-area, i.e., 100 per cent reimbursement up to the amount of the fee scheduled.

Coverage has been limited to groups.^{21/} The minimum percentages are 100 per cent minus one person for groups of 5-13 employees, and percent-
^{20/} Still in force, however, for clients of the Farm Security Administration.

^{21/} As of February 1, 1946 the enrollment of non-group subscribers was authorized.

ages graded down to 50 per cent for groups of 25 or more employees. New subscribers must be under 65 years of age. No income limit is set. Physicians are free to charge anyone a fee in excess of the fee schedule. Persons who have had cancer, diabetes, osteomyelitis, tuberculosis, chronic nephritis or coronary thrombosis are not eligible for service.

Two types of benefits are offered under current contracts. The surgical contract benefits include surgical and obstetrical service in home, office and hospital, limited to \$150 surgical fees in any one illness. Where two procedures are performed at the same time only the major one is paid for. In addition, there is an allowance in any one illness of \$10 for anesthesia and \$15 annually for diagnostic x-ray for surgical cases. During the first 10 months of membership, service is not rendered in menopausal conditions or hernia, hemorrhoid and tonsil operations, and for 12 months in pregnancy, childbirth, or related complications. Benefits are not available for pre-existing conditions or those arising from the use of drugs or alcohol. Waiting periods are waived for groups with a high percentage enrollment, and the members of such groups are also eligible for the care of pre-existing conditions.

The medical call rider to the surgical contract provides allowances of \$2 for physicians' hospital and office calls and \$3 for home visits, the number not to exceed one hospital visit per day, and 25 calls of all types annually for subscriber, and 15 for each dependent. No calls are allowed for 60 days after surgical procedures, except for medical complications, since surgical after-care is included in the fee for surgery. In addition to the surgical contract benefits, for each disability an allowance is made of \$5 for specialists' consultations and \$5 for endoscopic examination. For a contract year, a maximum of \$10 is allowed for each of the following: diagnostic x-ray, radiotherapy, physiotherapy, allergy tests, and laboratory tests (including basal metabolism at \$5). An allowance of \$5 each is made for electrocardiograms, with a maximum of \$15. Vaccinations, inoculations and refractions are not included. A married woman subscriber who has not been employed for 6 months is entitled only to dependents' benefits under this rider.

The surgical contract premiums are \$7.20 for an individual and \$20.40 for a family. The premiums for the surgical contract with medical rider are \$18.00 for an individual and \$36.00 for a family. Persons leaving the enrollment group may retain coverage at the same rate. However, they are billed quarterly or annually, and a \$.10 charge is made for each billing.

Central New York Medical Plan, Inc.

This plan, modeled after the Western New York Medical Plan, was introduced early in 1945. Although the plan may cover 10 counties, subscriptions are now being solicited in only 7. At present, coverage is limited to groups (employment, social or professional groups) and does not extend to anyone over 65 years of age, even though he was covered before attaining that age. The plan is on an indemnity basis, no income limit is set on subscribers, and the physician is at liberty to charge a fee in excess of the indemnity fee schedule. Charges are subject to review, on appeal, by a special board. Persons who have had cancer, diabetes, osteomyelitis, tuberculosis, chronic nephritis or coronary thrombosis are not eligible for enrollment.

A surgical contract and a medical call rider are offered. The surgical contract benefits include surgical and obstetrical service in home, office and hospital, limited to \$150 surgical fees and \$10 for anesthesia in any one illness, plus an annual total of \$15 for diagnostic x-ray for surgical cases. During the first 10 months of membership, benefits are not available in menopausal conditions, hernia, hemorrhoid and tonsil operations, and for 12 months in pregnancy, childbirth or related complications. However, waiting periods may be waived for groups with a high percentage of subscribers.

The medical call rider to the surgical contract provides allowances of \$2 for physicians' hospital and office calls, and \$3 for home visits, the number not to exceed one hospital visit per day, and 25 calls annually for subscriber, and 15 for each dependent. No calls are allowed for 60 days after surgical procedures except for medical complications, since surgical after-care is included in the fee for surgery. For each disability an allowance is made of \$5 for specialists' consultations and \$5 for endoscopic examination. For a contract year, a maximum of \$10 is allowed for each of the following: diagnostic x-ray,^{22/} radiotherapy, physiotherapy, allergy tests and laboratory tests (basal metabolism at \$5). An allowance of \$5 each is made for electrocardiograms, with a maximum of \$15. A married woman subscriber who has not been employed for 6 months is entitled only to dependents' benefits.

The surgical contract premiums are \$7.20 for an individual and \$20.40 for a family. The premiums for the surgical contract with medical rider are \$18.00 for an individual and \$36.00 for a family. Persons leaving

^{22/} This is in addition to x-ray benefits provided by the surgical contract.

their enrollment group may retain coverage at the group rate, with direct billing for the remainder of the contract year. At the end of the year, they are to be billed at a higher rate, which has not yet been determined.

Genesee Valley Medical Care, Inc.

This new plan will offer its contracts to the public early in 1946. Although its charter covers six counties, the plan was organized by the Monroe County Medical Society and, for the present, activities will be confined to Monroe County. Extension of the plan depends upon sponsorship by the medical societies of the other five counties.

At first, enrollment will be limited to groups of 5 or more acceptable persons, if the following minimum percentage enrollment is met: 100 per cent less one person for groups of 5-10 persons; 75 per cent but not less than 10 persons for groups of 11-25; 60 per cent for groups 26-50; and 50 per cent for groups of more than 50 persons. The age limit for initial enrollment is 65. Spouse, and dependents aged 90 days to 18 years may be covered. Persons who have had cancer, diabetes, osteomyelitis, tuberculosis, chronic nephritis or coronary thrombosis are not eligible.

Benefits are on an indemnity basis and the physician may charge a fee in excess of the fee schedule. Charges in excess of this amount may, on appeal, be reviewed by a special committee.

Only a surgical-obstetrical contract is to be offered. This provides surgical and obstetrical benefits in home, office and hospital, subject to a waiting period of 12 months for obstetrics, complications of pregnancy and childbirth, menopausal conditions, hernia and hemorrhoids. Where two or more procedures are performed in one period of disability but not at the same time, a maximum of \$150 is allowed. In addition, an allowance is made to subscriber and each dependent of \$15 annually for diagnostic x-ray for surgical cases, and \$10 in any one illness for anesthesia rendered by a physician other than the operating surgeon.

Benefits are not available for pre-existing conditions or those arising from use of drugs or alcohol.

Annual premiums for the plan are \$7.20 for individual and \$20.40 for family. Premium rates for persons leaving the group have not yet been set.

Medical and Surgical Care, Inc.

As a result of unfavorable financial experience under the more comprehensive surgical and medical call rider contracts issued previously, this Utica area plan now sells new low-priced and regular-priced surgical in-

demnity contracts and a medical call rider covering fewer benefits, although service under previous contracts is continued.

Individuals as well as groups are eligible, except that persons eligible to subscribe through a group may not subscribe individually. Coverage is restricted to persons under age 65.^{23/} Infants become eligible at 60 days. Dependents under 16 may be included under family contracts; dependents over 16 (other than spouse) may enroll as sponsored subscribers. Apparently as a result of unfavorable experience with married women who are not employed, married women are eligible only if their husbands enroll. Also, if a married woman who has been a subscriber ceases to be gainfully employed for a period of six months, she is entitled to benefits payable to dependents only. Except for obstetrics, surgical fees payable on behalf of dependents are only one-half as great as those for subscribers.

Surgical and obstetrical benefits in home, office or hospital are provided by the low-priced and regular contracts. The former allows a maximum of \$40 annually for prenatal care, delivery and post-natal care. The latter allows \$50 for prenatal care, delivery and post-natal care, and \$30 for miscarriage, \$75 for ectopic pregnancy, \$75 for caesarian section and \$25 for uterine curettage. The fees for other surgical procedures are somewhat lower for the low-priced contract.

A limited allowance is given for anesthesia (\$10 for both contracts), x-ray (\$5 and \$10 respectively), laboratory, basal metabolism and electrocardiogram (\$5 for all on the low-priced contract and \$7 for laboratory and \$5 for each of the others under the regular contract).^{24/} Benefits other than surgical and obstetrical are available in the hospital only, since abuses were experienced under previous plans where these were home and office benefits.

The medical call rider provides, for subscriber or dependent, \$2 per call at hospital or office and \$3 per call for home visits. The limit on calls is 1 per day, with a maximum of 21 hospital calls per illness, 3 home or office calls within 10 days of discharge from hospital (i.e., home or office calls are permitted immediately following hospitalization only), and 4 calls a week for contagious diseases. The maximum for calls of any type is 48 for subscriber and each dependent, not to exceed a total of 150 per year for a family. Allergy treatments, serum and medical injection

^{23/} Even if covered prior to attaining 65.

^{24/} The Blue Cross plan in the area does not include these benefits.

treatments, post-operative calls prior to the 60th day after operation, and services necessitated by pregnancy are not provided.

The premiums for the low-priced surgical plan are \$5.76 for a single person, \$11.88 for two persons, \$16.56 for a family including dependents under 16 years, and \$6.12 for each dependent (including sponsored subscribers) 16 years and over. The premiums for the regular plan are \$9.00, \$18.00 and \$22.80 respectively, with a \$9.00 charge for dependents aged 16 or over. The medical call rider premiums are \$4.80, \$9.00 and \$12.00 respectively, with a \$4.20 charge per dependent aged 16 or over. Premiums for group and individual coverage are the same; however, there is an enrollment fee for individually-enrolled subscribers.

Summary

Five voluntary non-profit medical care insurance plans are now operating in the State, another is to commence operations shortly, another has been organized, and an eighth is now being organized. These plans operate under the guidance of or in cooperation with the medical profession in the area. Their operations are based on the traditional pattern of medical practice. There is free choice of practitioner and patient. Participation is open to all physicians and, with the exception of the Health Insurance Plan of Greater New York, group practice is not involved. Payment is on a fee-for-service basis, possibly excepting the Health Insurance Plan of Greater New York, and usually there is no limit on the amount the physician may charge (although charges which seem excessive to the patient may be reviewed by a medical committee). Service plans, in which the physician agrees to accept payment by the plan as the full fee for his service to persons with incomes below a fixed limit, are offered by Group Health Cooperative and United Medical Service, and may be offered by the Health Insurance Plan of Greater New York.^{25/}

^{25/} Mr. Louis H. Pink, President of the Associated Hospital Service of New York (the Blue Cross plan which is under contract to operate United Medical Service) comments on these arrangements as follows:

"The medical profession has as a rule favored a financial arrangement that gives individuals more purchasing power without in any way binding the doctors.... If medical care were organized on a service basis similar to Blue Cross hospitalization, on the other hand, the medical profession would be able to provide more adequate medical care for the great mass of the people. Where such plans are established, the chief controversy is how high income of the subscriber may be and still entitle him to service without extra charge. In some states, the medical profession has been unrealistic about this and has made the income ceiling so low that there is no popular appeal." (Story of Blue Cross, Public Affairs Pamphlet No. 111, 1945.)

In general, benefits are strictly limited and defined. The control of quantitative abuses that may occur within these limits is based on rulings of the medical review boards of the plans, and the weight of medical opinion. There seems to be no mechanism for review or supervision of the quality of service rendered.

Comparison of the plans to determine which goes farthest towards meeting the public needs at the least cost is extremely difficult. Benefits, eligibility requirements and rate structures vary considerably. The medical insurance organizations which find it necessary to include in their contracts benefits which in other areas are provided by hospitalization insurance plans are correspondingly more expensive. Also, administrative costs may vary.^{26/}

It is more expensive to provide benefits to all types of subscribers than to group subscribers exclusively, since employed persons on the average require less care, and since a favorable distribution of risks is assured. Likewise, it is more expensive to issue contracts to all persons regardless of previous illnesses than to issue them only to persons who have had favorable past experience. The employed person in good health finds it relatively cheap to purchase a contract sold only to groups or only to good risks. Other persons are not so fortunate, either being required to pay more, or being quite ineligible for enrollment. From a community standpoint, a plan with broader eligibility is desirable.

The experience of the plans is interpreted as showing that self-supporting voluntary medical care insurance plans cannot gain wide membership. Some form of subsidy on behalf of persons of low income, and persons who are poor health risks, would be necessary to attain coverage of a majority of the population. The inclusion of medical home and office benefits does not seem immediately feasible because of difficulties in preventing abuses or excessive use of services which are not as tangible as surgery, obstetrics, x-ray and laboratory examination, or as susceptible to control as in-hospital care.

^{26/} Most of the plans which are administered by Blue Cross organizations are charged a percentage of total administrative cost of the organization based on proportionate premium income of the medical and hospital plans, despite the higher relative cost of administering the medical plans. Thus, such medical plans effect a saving in more efficient billing, selling, etc. procedures, and also in that the Blue Cross plans absorb some of their costs of operation. The Rochester plan, when it begins operations, will be charged for administration on a cost basis for the initial period, at least. Group Health Cooperative administers its own plan, and so cannot effect the economies of the other plans.

CHAPTER XIII

FACILITIES FOR MEDICAL CARE

Two most important barriers to the receipt of adequate medical care by all people are lack of ability to pay for care, and lack of facilities to provide the necessary care. It is often claimed that if the economic barrier were removed, e.g., by means of a State-wide medical insurance program, there would not be sufficient doctors, dentists, nurses and hospitals to meet the demands and purchasing power of the people. Some people believe that the ability to purchase medical care should not be increased unless facilities have been previously increased.

Although it is true that demand should not greatly exceed supply, it seems obvious that it is increased purchasing power which causes an increase in facilities, rather than the reverse. A hospital will not be constructed where none existed before unless there is some assurance that funds will be forthcoming from public or private sources to permit the hospital to operate and render service to the people of the community. Physicians and dentists will not establish practices in a community unless there is a strong probability that the people of that community will be able to pay them for their services. On the other hand, it would not be desirable to incorporate in a medical care program benefits which could not be provided in relatively full measure. To do so would create disappointments for the contributors to the costs, or greatly inflated prices, or both.

One of the questions that needs to be decided for New York State is the extent to which its facilities would be adequate to meet the demands for medical care if the economic barrier were completely or largely removed. It is the purpose of this and the following chapter to describe the existing facilities and, wherever possible, to measure them against standards for adequate care.

Physicians

An estimate was made of the number and type of physicians required to provide an adequate volume of medical service. The importance of arriving at an accurate figure, and the numerous variables which may affect the result, require that the method employed be presented in some detail. The definition of adequacy employed was that of Lee and Jones:^{1/}

^{1/} The Fundamentals of Good Medical Care, R. T. Lee and L. W. Jones, Publication No. 22 of the Committee on the Costs of Medical Care, University of Chicago Press, 1933.

Adequate medical care has both a quantitative and a qualitative aspect. It means a sufficient quantity of good medical care to supply the needs of the people according to the standards of good current practice.

Volume of service required. The volume of service required for adequate medical care has been taken with only minor changes, from the Lee-Jones Study.^{1/} Their data are based upon three variables - expectancy of disease, age distribution of the population, and standards of medical practice.

Lee and Jones utilized annual expectancy rates from 31 studies. These were carefully evaluated and a most probable rate established for individual diseases and groups of diseases, according to age groups. All disease conditions which require any type of medical care were included. In this study, the Lee-Jones expectancy rates were adjusted to the age distribution of the New York State population as given in the 1940 census. The services required for adequate diagnosis and treatment of the various diseases were estimated by Lee and Jones on the basis of opinions and case records of leading practitioners of medicine. The figures were subdivided to show for average cases in each disease category, the number of visits that should be made by a general practitioner, the number of consultations necessary, the number and types of operations needed, and the number of treatments that should be given by a specialist. Figures for x-ray examinations, laboratory examinations, and physiotherapy were also established.

As pointed out by Lee and Jones, it is impossible to determine once and for all time the services which will represent adequate medical care, because the expectancy of disease and the standards of good medical practice are constantly changing. The figures of Lee and Jones are now about 12 years old, and in examining them in detail it is evident that considerable changes have occurred over a period of years. For example, rickets and diphtheria are no longer the problems they were; on the other hand, chronic diseases such as cancer and diabetes are more prevalent. As regards standards of medical practice, the use of the sulfonamides and penicillin has reduced the services required in a number of diseases, but new surgical technics have made it possible to perform a number of other operations which were uncommon or unknown a few years ago. However, it appears that a decreased need for medical services in certain categories is balanced by an increased need in other categories. Lee and Jones believed that their rates "would probably exceed even the immediate total need for medical care, and would undoubtedly be an over-

estimate of future needs." It seems safe to assume that although there may be qualitative differences between the services considered necessary by Lee and Jones in 1933 and the services that would be required today, there is little quantitative difference.

Diseases covered and services provided. The diagnosis and treatment of the diseases and conditions shown in Table 1 are covered. A few items of service, such as medical assistance to the surgeon at operation, and general anesthesia, have not been included because data are lacking. The expectancy rates cover all conditions for which medical care is required, except for the treatment of tuberculosis, psychosis, feeble-mindedness, neurosis, behavior problems and institutionalized cases of neurosyphilis. Although rates have not been derived for every individual disease, they are shown for certain important diseases, e.g., appendicitis, rheumatic heart disease, etc., and the use of inclusive rates for diseases remaining in broad disease categories has made it possible to cover all conditions.

Table 2. Physician Time Required for Specified Types of Medical Service.

General practitioner		Specialist	
Service	Minutes	Service	Minutes
Diagnosis		a/ Treatment	
Respiratory	20	Nose & throat	15
Gastrointestinal	40	Internist	15
Genitourinary	40	Surgeon	20
Communicable	15	Obstetrician	20
General diseases	30	Urologist	30
Female genital	15	Gynecologist	30
Muscles, joints, etc.	20	Orthopedist	30
Treatment		Neurologist	45
Respiratory	15	Psychiatrist	60
Gastrointestinal	15	Ophthalmologist	30
Genitourinary	15-30	Dermatologist	10
Communicable	15-20	Operation	
General diseases	15	Nose & throat	10-60
Female genital	15	Appendix	30
Muscles, joints, etc.	15-20	Hernia	40
Syphilis	20	Gall-bladder	60
Gonorrhea	10	Female genital	30-60
Lacerations	10-15	Orthopedic	30-150
Fractures	30-75	Genitourinary	60-90
First prenatal	45	Post-operative	5-15
Other prenatal	15	Follow-up	10-15
		Delivery	360

Figures are for routine visits. In the calculations, an additional 15 to 30 minutes is usually allowed for first diagnostic visit, or consultation.

Time required per visit. The time required per unit of service is exclusive of travel time. It applies to individual services (visits) rather than the time required to conclude a case of a given disease, e.g.,

Table 1. Diseases Covered in Study of Physicians' Services Required for Adequate Medical Care

Respiratory	Digestive
Colds, bronchitis, sinusitis	Indigestion, nausea, diarrhea, enteritis
Infuenza and grippe	Ulcer of stomach and duodenum
Tonsillitis, pharyngitis, etc.	Appendicitis
Pneumonia, all forms	Hernia
Hay fever and asthma	Diseases of liver and biliary system
	Other diseases of digestive system
Acute Communicable	Skin
Measles	Boils, carbuncles, abscesses & ulcers
Whooping cough	Scabies
Chickenpox	Urticaria
Mumps	Dermatitis
Scarlet fever	Impetigo
Diphtheria	Eczema
Typhoid fever	Other skin diseases
All other	
Injuries	Female Genital (non-venereal)
Cuts, abrasions, bruises	Disorders of menstruation, including menopause
Fractures	Sterility (including cervicitis, uterine displacement, etc.)
Sprains and Strains	Cysts and tumors
Infected wounds	Pelvic lacerations
Poisoning	Salpingitis
Burns	
Puerperal	Ear and Mastoid
Prenatal	Otitis media
Delivery and post partum	Earache
	Mastoid
Syphilis and Gonorrhea	All other
General	Muscles, Bones and Joints
Rheumatic conditions, acute and chronic	Lumbago, backache, myositis, etc.
Cancer and other tumors (except female genital)	Strained feet (disabling)
Diabetes	Spinal curvature
Rickets	
Goiter and glandular conditions	Kidneys and Annexa
Anemia	Acute nephritis
Drug addiction and chronic alcoholism	Chronic nephritis
Pellagra	Urinary and renal calculi
	Cystitis
Heart and Arteries	Floating kidney
Arteriosclerosis & arteriosclerotic heart disease	Pyelitis
Rheumatic heart disease	Circulatory System (except heart)
Syphilitic heart disease	Hemorrhoids
Heart disease from other causes	Varicose veins and ulcers
Hypertension	Varicocele
	Aneurysm
Eye and Annexa	Phlebitis
Conjunctivitis, including trachoma	Male Genital (non-venereal)
Stye	Prostatic disease
Eye strain	Urethral stricture
Iritis	Hydrocele
Glaucoma	Phimosis
Cataract	Orchitis
Gonorrheal ophthalmia	
Neuralgia, Neuritis & Sciatica	Nervous and Mental
Neurasthenia & Nervous Exhaustion	Epilepsy
Eye - Refractive Errors	Multiple sclerosis
	Brain tumors
	Chorea

one case of respiratory disease might require only one diagnostic visit - 20 minutes, another case might require two visits - a total of 40 minutes, and so on. Representative figures used in these calculations are set forth in Table 2. They correspond closely with the average time per visit reported in other studies.^{2/3/}

Physicians needed. The product of time, services required, and disease expectancy equals the physician-hours required. This figure was calculated for each disease category and, within the category, for general practitioners and the various types of specialists. A summary of the results is shown in Table 3. The figure perhaps should be termed "patient-hours" because it refers only to time spent by the physician in attendance on a patient and does not include time for travel, study, the business end of practice, etc. Refractions are shown separately because they may be performed either by an ophthalmologist (physician) or by an optometrist.

Although physicians are reported as working 50-60 hours per week,^{1/3/} it seems doubtful whether the average physician should devote more than 30 hours per week to the actual care of patients, the remainder of his time being spent in travel, study and the business aspects of practice. Allowing 30 hours per week, 48 weeks per year, the average physician could spend 1,440 hours in seeing patients.

To reconcile the differing specialty classifications employed by Lee and Jones, the American Boards of Medical Specialties and the New York State Workmen's Compensation program, it has been necessary to adopt the groupings shown in Table 4. There are many physicians not qualified by the Boards who possess more experience than the average physician, who limit their practice to a given specialty, and who have been classified as specialists for the purpose of participating under the New York State Workmen's Compensation Law. These have been included in the tabulations of specialists.

New York State physicians. A study was made of the distribution of general practitioners and specialists listed in the Medical Directory of New York,^{4/} and the specialists in the Directory of Medical Specialists,

2/ In "A Note on Physician Time per Patient in Private Practice," B. M. Davis, Public Health Reports, 60:1113, Sept. 21, 1945 an average of about 17 minutes was reported. A. Ciocco and I. Altman, in "Statistics on the Patient Load of Physicians in Private Practice," J.A.M.A. 121:506 (1943), state that the average office visit is of about 17 minutes duration (actually, 16.6 minutes).

3/ The inclusive figure for all services, including operative, travel to visit patients, etc., averaged 20 minutes in 1943, according to "Specialists' Economic Status," Medical Economics, 23:50, October 1945.

4/ Medical Directory of New York, New Jersey and Connecticut, 1941-42, Medical Society of the State of New York. There are listed, as of May 1, 1941, the physicians who have registered with the various county clerks, as required by law, their licenses to practice medicine in this State.

Table 3. Physician-Hours Required per 1000 Population of All Ages, for Specified Disease Groups and Medical Practitioners.
(Based on Lee-Jones Study¹; Adjusted to Age Distribution of New York State Population, 1940)

Disease group	General practitioner	Internist	Syphil-ologist	Dermat-ologist	Neur-ologist	Psych-iatrist	Obstet-rician	Ear, nose, throat	Surg-eon	Urol-ogist	Gynec-ologist	Ortho-pedist	Ophthal-mologist	All physi-cians
Respiratory a/	493.38	21.33	....	....	....	....	....	51.80	....	....	....	....	....	545.51
Digestive	167.88	4.47	....	....	....	....	....	....	37.02	....	....	....	....	209.37
Acute communicable	74.99	2.72	....	....	....	....	....	.28	1.42	....	....	.15	....	79.56
Injuries	45.87	....	....	....	....	....	....	....	9.86	....	....	.68	....	56.41
Puerperal	200.23	....	....	....	....	....	20.24	....	....	....	....	....	....	220.47
Venereal	55.35	.18	9.33	....	....	....	....	....	....	17.80	4.83	....	.43	87.92
General diseases	66.76	69.73	....	....	....	....	....	.36	23.66	....	....	1.10	....	161.61
Skin	13.08	....	....	2.74	....	....	....	....	.53	....	....	....	....	16.35
Female genital	35.65	....	....	....	....	....	....	....	....	.43	17.76	....	....	53.84
Ear and mastoid	7.12	....	....	....	....	....	....	12.49	....	....	....	....	....	19.61
Muscles, joints, etc. a/	15.52	.20	....	....	....	....	....	.10	....	.15	.05	10.80	....	26.82
Kidney & annexa	66.47	1.68	....	....	....	....	....	.01	.11	8.85	....	....	....	77.12
Heart & arteries	94.40	2.18	....	....	....	....	....	.43	....	....	....	....	....	97.01
Eye & annexa b/	.74	1.79	....	.26	....	....	....	.61	....	....	....	....	21.09	24.49
Circulatory	4.49	.08	.003	....	....	....	....	....	5.40	....	....	....	....	9.97
Male genital	.93	....	....	....	....	....	....	....	....	8.86	....	....	....	9.79
Neuralgia, etc.	18.29	....	....	....	....	....	....	....	....	.08	.08	2.63	....	23.71
Neurasthenia	29.97	....	....	....	.31	20.62	....	....	....	....	....	....	....	50.90
Nervous & mental c/	10.11	.02	....	....	5.38	5.81	....	....	....	....	....	....	....	24.64
Total	1401.23	104.38	9.33	3.00	8.32	26.43	20.24	46.10	81.30	36.17	22.72	15.36	21.52	1796.10

a/ Exclusive of treatment of tuberculosis.

b/ Exclusive of refractions, 137 hours.

c/ Exclusive of psychosis, feeble-mindedness, neurosis, behavior problems and institutionalized neurosyphilis.

Table 4. Reconciliation of Differing Classifications of Physicians by Type of Practice.

Lee-Jones	American Medical Specialties Board	Workmen's Compensation <u>a/</u>	Reconciliation of classifications	Physician - hours needed <u>b/</u>
General practitioner	Pediatrician	General practitioner Physical therapy	General practitioner	1,401.23
Internist Syphilologist	Internist Dermatologist & syphilologist	Internal medicine Dermatology and/or syphilology Tuberculosis & lung diseases Gastroenterology Cardiology Metabolic diseases Immunology & allergy Endocrinology	Internist	113.71
Neurologist Psychiatrist	Neurologist & psychiatrist	Neurology and/or psychiatry Psychiatrist <u>c/</u>	Neuropsychiatrist	34.75
Obstetrician Gynecologist	Obstetrician & Gynecologist	Obstetrics and/or gynecology	Obstetrician & gynecologist	42.96
Ear, nose & throat	Ear, nose & throat	Laryngology Rhinology and/or otology Bronchoscopy	Ear, nose & throat	46.10
Surgeon	Surgeon Neurosurgeon Plastic surgeon	Gen. surgery, major Traumatic surg., not major Minor surgery Plastic surgery Proctology Neurosurgery Oral surgery Vascular & venotherapy	Surgeon	81.30
Urologist	Urologist	Genitourinary diseases	Urologist	36.17
Orthopedist	Orthopedic surgeon	Orthopedic surgery	Orthopedist	15.36
Ophthalmologist	Ophthalmologist	Ophthalmology	Ophthalmologist	21.52 <u>d/</u>
	Anesthetist Pathologist Radiologist	Anesthesia pathology & laboratory Radiation and/or roentgenology Public health & industrial Full-time <u>e/</u>	Other types of practice	

a/ Does not include specialists qualified by American Boards, who are in previous column. Covers physicians with "SD" qualifications, i.e., physicians whose practice is limited to the specialty.

b/ Per 1000 population.

c/ Qualified by New York State Department of Mental Hygiene.

d/ Exclusive of refractions.

e/ Chiefly hospital and public health administrators, but including qualified specialists who are full-time in mental and similar hospitals.

1942.^{5/} Table 5 shows the distribution of physicians by county. In Table 6, comparison is made of the number of general practitioners and

Table 5. Distribution of Physicians by County, New York State, 1941.^{4/}

County	No. of physicians	County	No. of physicians
Rochester District		Albany District	
Allegany	43	Albany	383
Chemung	97	Clinton	59
Genesee	52	Columbia	49
Livingston	62	Essex	58
Monroe	694	Franklin	71
Ontario	94	Fulton	67
Orleans	33	Greene	38
Schuyler	12	Hamilton	7
Seneca	37	Montgomery	61
Steuben	98	Rensselaer	160
Wayne	56	Saratoga	84
Wyoming	44	Schenectady	174
Yates	34	Schoharie	24
Total	1,356	Warren	73
Buffalo District		Washington	57
Cattaraugus	92	Total	1,365
Chautauqua	143	Syracuse District	
Erie	1,217	Broome	246
Niagara	180	Cayuga	82
Total	1,632	Chenango	40
New York District		Cortland	42
Bronx & New York	9,952	Delaware	48
Dutchess	238	Herkimer	67
Kings	4,700	Jefferson	102
Nassau	638	Lewis	21
Orange	212	Madison	57
Putnam	29	Oneida	301
Queens	1,765	Onondaga	478
Richmond	163	Oswego	71
Rockland	128	Otsego	78
Suffolk	350	St. Lawrence	99
Sullivan	62	Tioga	42
Ulster	113	Tompkins	88
Westchester	1,155	Total	1,862
Total	19,505	State	25,720

specialists in 1941, with the number needed as estimated by this study, for the whole State and for each of the five large geographic districts shown in Table 5.^{6/} In interpreting Table 6, several facts are to be kept in mind. The number of specialists listed in the Directory of Medical Specialists (3,758) does not agree with the number derived from the Medical Directory of New York (3,344), partly due to the inclusion of a number of specialists in the "Other types of practice" classification in 5/ Directory of Medical Specialists, 1942, Columbia University Press, New York, 1942.

6/ See section on general hospitals, Chapter XIV, for a description of these geographic districts.

the tabulation made from the latter, which are the figures employed in this study. The total number of physicians tabulated (25,720) does not agree exactly with the total in the Medical Directory of New York (25,730), possibly due to a few omissions, or to the elimination of duplicates in the process of tabulating. A majority of the State's 2,000 internes and residents^{7/} do not appear in the Medical Directory of New York, although they contribute in good measure toward the care of patients. On the other hand, the number of physicians is diminished by a proportion who are retired or otherwise not in active practice. This number is not known on the basis of Medical Directory of New York figures. In a study made by the State Department of Health in December 1942, it was found that 7 per cent of physicians outside of New York City fell in this classification, but the Health Department's study covered many physicians not listed in the Directory. Thus, it is believed that the figures employed herein tend to represent quite accurately the number of physicians who are engaged in the care of patients, exclusive of internes, residents, teachers in the preclinical medical sciences, etc.

From Table 6 it appears that each district of New York State possesses sufficient physicians in total to provide medical care adequate according to the Lee-Jones standards. The New York City district has more than enough physicians, approximately 7,000 in excess. In the case of the latter, allowance should be made for the fact that New York City physicians serve many people who reside in New Jersey, Connecticut and other States, but even after a generous allowance is made there is a substantial surplus. In respect to specialists, the number qualified by the American Medical Specialties Boards is obviously insufficient. If, however, there is included those who limit their practice to special branches of medicine and who are recognized as specialists under Workmen's Compensation, the number corresponds closely with the number needed for adequate care.

Table 7 shows for each district the deficit or surplus in each category. Outside of the New York City district there is a significant deficit in the specialties of internal medicine, urology, and obstetrics and gynecology. It is possible, however, that these deficits are more apparent than real, since they are types of practice which are not in great demand under Workmen's Compensation, and physicians limiting their practice to these branches of medicine may not have troubled to apply for certification. The apparent surplus in ophthalmologists is qualified by the fact that in es-

^{7/} "Hospital Service in the United States", Journal of the American Medical Association, 124:839, March 25, 1944.

Table 6. Distribution of Physicians in New York State by Location and Type of Practice, 1941, Compared with Number of Physicians Needed for Adequate Medical Care.

Classification of physicians	Number needed	Actual number		
		Total	Diplomates	Others <u>a/</u>
ALBANY DISTRICT				
PRACTICING PHYSICIANS	1,134	1,276	91	1,185
General practice	923	1,005	10 <u>b/</u>	995
Internal medicine	78	44	13	31
Neuropsychiatry	23	25	10	15
Obstetrics & gynecology	23	20	13	7
Ear, nose & throat	30	22	15	7
Surgery	54	96	11	85
Urology	24	8	5	3
Orthopedics	10	12	3	9
Ophthalmology	14	44	11	33
OTHER TYPES OF PRACTICE	-	39	-	-
Full-time <u>c/</u>	-	61	-	-
Certain specialists <u>d/</u>	-	23	12	16
GRAND TOTAL	-	1,355	103	
BUFFALO DISTRICT				
PRACTICING PHYSICIANS	1,440	1,527	136	1,391
General practice	1,124	1,176	12 <u>b/</u>	1,164
Internal medicine	94	82	36	46
Neuropsychiatry	28	26	2	24
Obstetrics & gynecology	34	15	11	4
Ear, nose & throat	37	40	23	17
Surgery	65	105	16	89
Urology	29	15	12	3
Orthopedics	12	10	8	2
Ophthalmology	17	53	16	42
OTHER TYPES OF PRACTICE	-	105	-	-
Full-time <u>c/</u>	-	53	-	-
Certain specialists <u>d/</u>	-	52	24	28
GRAND TOTAL	-	1,632	160	-
ROCHESTER DISTRICT				
PRACTICING PHYSICIANS	1,170	1,271	107	1,164
General practice	911	1,032	16 <u>b/</u>	1,016
Internal medicine	77	51	22	29
Neuropsychiatry	23	14	4	10
Obstetrics & gynecology	28	13	10	3
Ear, nose & throat	30	24	18	6
Surgery	53	65	11	54
Urology	24	13	5	8
Orthopedics	10	17	6	11
Ophthalmology	14	42	15	27
OTHER TYPES OF PRACTICE	-	85	-	-
Full-time <u>c/</u>	-	52	-	-
Certain specialists <u>d/</u>	-	33	17	16
GRAND TOTAL	-	1,356	124	-

Table 6 (continued).

Classification of physicians	Number needed	Actual number		
		Total	Diplomates	Others <u>a/</u>
SYRACUSE DISTRICT				
PRACTICING PHYSICIANS	1,652	1,743	144	1,599
General practice	1,239	1,380	15 <u>b/</u>	1,364
Internal medicine	108	72	29	43
Neuropsychiatry	32	24	6	18
Obstetrics & gynecology	39	14	10	4
Ear, nose & throat	42	39	33	6
Surgery	75	129	18	111
Urology	33	14	7	7
Orthopedics	14	10	7	3
Ophthalmology	20	61	18	43
OTHER TYPES OF PRACTICE	-	119	-	-
Full-time <u>c/</u>	-	73	-	-
Certain specialists <u>d/</u>	-	46	27	19
GRAND TOTAL	-	1,862	171	-
NEW YORK DISTRICT				
PRACTICING PHYSICIANS	11,624	18,605	2,449	16,156
General practice	9,065	14,453	271 <u>b/</u>	14,182
Internal medicine	761	885	508	377
Neuropsychiatry	225	450	186	264
Obstetrics & gynecology	277	341	278	63
Ear, nose & throat	298	585	503	77
Surgery	526	1,010	195	815
Urology	234	199	122	77
Orthopedics	99	221	116	105
Ophthalmology	139	461	265	196
OTHER TYPES OF PRACTICE	-	900	-	-
Full-time <u>c/</u>	-	436	-	-
Certain specialists <u>d/</u>	-	464	337	127
GRAND TOTAL	-	19,505	2,786	-
ENTIRE STATE				
PRACTICING PHYSICIANS	17,070	24,422	2,927	21,495
General practice	13,312	19,046	325 <u>b/</u>	18,721
Internal medicine	1,118	1,134	603	526
Neuropsychiatry	331	539	208	331
Obstetrics & gynecology	406	403	322	81
Ear, nose & throat	437	710	597	113
Surgery	773	1,405	251	1,154
Urology	334	249	151	98
Orthopedics	145	270	140	130
Ophthalmology	204	666	325	341
OTHER TYPES OF PRACTICE	-	1,298	-	-
Full-time <u>c/</u>	-	675	-	-
Certain specialists <u>d/</u>	-	623	417	206
GRAND TOTAL	-	25,720	3,344	-

a/ Workmen's Compensation classification of physicians other than diplomates. An individual physician was counted only once, being assigned to the highest or most inclusive classification.

b/ Pediatricians.

c/ Includes some specialists, administrators, residents, etc.

d/ Anesthesiology, pathology, radiology, public health and industrial medicine.

Note: For the State as a whole, the full time of 1300 persons, either ophthalmologists or optometrists (30 hour week, 48 weeks per year), would provide the necessary refractions.

timating the number needed, eye refraction was not included. If this service were to be performed entirely by ophthalmologists, a number greatly in excess of that shown would be needed. On the other hand, such deficit is cancelled if one takes into account the 1,620 registered optometrists in the State who are available to do refractions (see footnote to Table 6).

These calculations are interpreted as showing that the number of physicians in New York State in normal times (1941) is sufficient from the standpoint of total number, geographic distribution and special qualifications, to provide adequate medical care of the volume that would be anticipated if there were no economic barrier. As a check on these figures, reference was made to the recent studies of Ciocco and Altman.^{8/} They estimate the maximum working capacity of the average general practitioner to be between 125 and 160 patients weekly, and the number actually seen to average about 112. The average number of patients seen by specialists of all types was of the same order. In the study described herein, a work-week of 30 hours exclusive of travel, etc. was employed, which, at an average per visit time of 17 minutes, would result in an average of 106 patients weekly. On the basis of a 48 week year, the average physician could see 5,088 patients. Applying this figure to the number of practicing physicians in a district and dividing by the population of that district yields the average potential number of physician-services per person per year, as shown in Table 8.

Table 7. Surplus or Deficit of Physicians According to Location and Type of Practice, as Determined by Comparison with Estimated Numbers Needed for Adequate Medical Care.

Classification of physician	District					Sum of deficit	Sum of surplus
	Alb-any	Buff-alo	Roch-ester	Syra-cuse	New York		
General practice	+ 82	+ 52	+121	+ 91	+5,388	--	5,734
Internal medicine	- 34	- 12	- 26	- 36	+ 124	108	124
Neuropsychiatry	+ 2	- 2	- 9	- 8	+ 225	19	227
Obstetrics & gynecology	- 8	- 19	- 15	- 25	+ 64	67	64
Ear, nose & throat	- 8	+ 3	- 6	- 3	+ 287	17	290
Surgery	+ 42	+ 40	+ 12	+ 54	+ 484	--	632
Urology	- 16	- 14	- 11	- 19	- 35	95	--
Orthopedics	+ 2	- 2	+ 7	- 4	+ 122	6	131
Ophthalmology a/	+ 30	+ 41	+ 28	+ 41	+ 322	--	462
Sum of deficit	66	49	67	95	35	312	--
Sum of surplus	158	136	168	185	7,016	--	7,664

a/ Does not include refractions. See text, and footnote to Table 6.

^{8/} "The Patient Load of Physicians in Private Practice", A. Ciocco and I. Altman, Public Health Reports, 58:1329, Sept. 3, 1943.

Table 8. Estimated Average Number of Services (Visits) per Person Per Year That Could be Given by New York State Practicing Physicians. a/

District	General practitioner	All physicians
Albany	5.44	6.85
Buffalo	4.90	6.36
Rochester	5.55	6.34
Syracuse	5.25	6.63
New York	7.89	10.16

a/ Exclusive of internes and residents.

if included, the figures would probably be about 3 to 5 per cent higher.

The figures in Table 8 are to be compared with those of Ciocco and Altman, as shown in Table 9. The latter excludes radiology, industrial medicine and surgery, clinical pathology and anesthesiology, as does Table 8. However, clinic service is excluded from the latter;

Table 9. Estimated Annual Services Per Person Obtained from Private Physicians (Adapted from Ciocco and Altman). 8/

Type of practice	District of Columbia	Balti-more	Mary-land	Urban Georgia	Total Georgia
General practitioners <u>a/</u>	3.37	3.90	3.42	3.08	2.53
All physicians	5.86	6.17	4.67	4.89	3.14

a/ Male white general practitioners, Negro male, and female physicians.

The significant figures are "all physicians". They tend to be high in Baltimore and the District of Columbia because many non-residents come to those localities for care. A reasonable figure for services per person per year would seem to lie between 5.0 and 5.5. It appears on the basis of these calculations also, that each district of New York State possesses sufficient physicians to supply an adequate volume of care.

Hospital affiliation of physicians. It is considered desirable for all practicing physicians to be affiliated with a hospital in order that they may continue therein the care of patients begun outside of the hospital, that both patient and physician may benefit from the special facilities for diagnosis, observation, consultation and treatment that the modern hospital affords, and that the physician may keep abreast of medical progress through informal contacts with hospital staff members and through regular meetings and conferences of the hospital staff.

Very few hospitals are open to any physician who wishes to practice therein. In 1943 there were, exclusive of maternity homes and institutions for nervous and mental disease, only 55 general hospitals, containing 3,500 beds (about 5 per cent of the State's total), which were under the management of individuals, partnerships or profit corporations, and some of which may be assumed to have been open to all physicians. The public and voluntary (church and non-profit association) hospitals, with few exceptions have closed staffs; i.e., only physicians who have qualified in

some respect are entitled to practice in such hospitals. The matter of staff membership is somewhat confused by a further division into regular and courtesy staffs, the latter not being accorded equal privileges with regular staff members and not having a voice in determining professional policies within the hospital.

There is much to be said in defense of the closed-staff system. The hospital has a moral responsibility to the public for the professional care rendered by its staff members, and a responsibility to the internes and nurses who obtain their training in the hospital. To discharge these responsibilities, the hospital must be able to select its staff members with regard to professional and teaching ability, and must be able to exert some control over them. Many hospitals prohibit their staff members from undertaking operations, certain complicated obstetrical procedures, etc., unless the physician is eminently qualified or unless the procedure is undertaken following consultation with or under the supervision of a well-qualified physician. Also, difficult or instructive cases (e.g., obstetrical cases resulting fatally) are reviewed at regular conferences, material removed at operation or autopsy is studied, and new or improved methods of diagnosis and treatment are discussed. There is no doubt that the closed-staff system affords one of the most effective methods of post-graduate medical education yet developed, and that it has done much to prevent needless surgery and obstetrical fatalities, and to elevate generally the quality of medical care.

Against the closed-staff system it may be said that admission to the staff may be contingent on factors other than professional ability and conduct, and that it may deprive of instruction and guidance precisely those physicians who stand most in need of it. The problem is not one that is easy of solution, because present hospital staff organization is not prepared to embrace all physicians. Neither are all physicians who are not hospital staff members willing to shoulder the duties and responsibilities that go with the privileges of staff membership. The solution, if any, would seem to lie in a regional federation of hospitals around teaching institutions, to bring in the institutions not now having regular staff organizations, and a broadening of the scope of staff membership to include subsidiary grades.

Table 10 shows the percentage of physicians holding medical staff appointments in voluntary, State and municipal hospitals, as of May 1, 1941, as recorded in the Medical Directory of New York, 1941-42. ^{4/}

Table 10. Percentage of Physicians with Hospital Affiliations, New York State, 1941.

District	Total physicians	Per cent with hospital affiliation
New York	19,505	63.9
New York City	16,580	63.9
Manhattan	7,848	63.6
Bronx	2,104	63.9
Brooklyn	4,700	65.1
Queens	1,765	61.8
Richmond	163	66.3
Rest of district	2,925	63.9
Albany	1,365	51.3
Buffalo	1,632	57.4
Syracuse	1,862	59.7
Rochester	1,356	57.9
State	25,720	62.2

The figure of 64 per cent for New York City and vicinity is slightly higher than that for the rest of the State, 57 per cent.

Dentists

An estimate has been made of the number of dentists required to furnish adequate dental care, employing the Lee-Jones Study^{1/} data described previously.

Volume of service re-

quired. The expectancy of dental disease is based upon 17 studies, from which most probable rates were derived for various age groups. Partly because of its expensive nature and partly because it does not cause marked disability, there has been allowed to accumulate over a period of years a great reservoir of dental defects. The volume of service calculated does not cover the accumulated dental defects, but simply aims to deal with the average annual incidence of dental decay, etc., in addition to providing prophylactic service currently. Because it would obviously be impossible immediately to furnish persons of all ages with adequate dental service, estimates have been made for various age groups and for certain types of service, such as extractions, which might be feasible of inclusion in a general medical care program. On the supposition that many cases which now require orthodontia as the result of malocclusion due to premature loss of teeth would escape such need if given adequate dental care in earlier years, the expected incidence of orthodontic treatment is low. Adequate dental care is also expected to somewhat reduce the need for extensive fillings, extractions and complete or partial dentures.

The standards of good dental care require, in addition to the treatment of dental disease, semi-annual visits to the dentist for prophylaxis, and the liberal use of x-rays for diagnosis. The services covered include oral prophylaxis, x-ray, fillings, extractions, crowning, bridges and dentures, and treatment of gum conditions.

The number of dentists needed to supply adequate dental care for all residents of the State would be 35,750, as shown in Table 11. This is more

Table 11. Dentist-Hours and Dentists Needed for Adequate care, New York State. 1/

Age group	Dentist-hours per person per year					Popula- tion (millions)	Service needed	
	General dentist	Eko- dentist	Ortho- dentist	X-ray	Total		Hours (millions)	Dentists a/ (millions)
3-4	1.85	-	-	.09	1.94	.340	.660	425
5-17	3.00	.06	.47	.40	3.93	2,924	11,477	7,651
18-44 b/	3.30	.22	-	.78	4.30	6.12	26,304	17,534
45 & over b/	3.08	.24	-	.56	3.88	3.92	15,206	10,136
Total	-	-	-	-	-	13.504	53,647	35,747

a/ It is assumed that each dentist would work 1500 chair and laboratory hours per year.

b/ A total of 3.6 hours for adults has been recommended in other studies, see Footnote 11.

Table 12. Distribution of Dentists by County and District, New York State, 1941-9/

County	Number	County	Number
Rochester District		Albany District	
Allegany	19	Albany	122
Chemung	35	Clinton	16
Genesee	20	Columbia	14
Livingston	21	Essex	17
Monroe	309	Franklin	24
Ontario	23	Fulton	24
Orleans	12	Greene	13
Schuyler	6	Hamilton	1
Seneca	11	Montgomery	29
Steuben	39	Rensselaer	53
Wayne	20	Saratoga	24
Wyoming	11	Schenectady	65
Yates	5	Schoharie	10
Total	534	Warren	22
Buffalo District		Washington	14
Cattaraugus	40	Total	448
Chautauqua	60	Syracuse District	
Erie	524	Broome	69
Niagara	30	Cayuga	33
Total	704	Chenango	13
New York District		Cortland	13
Bronx & New York	4,253	Delaware	14
Dutchess	67	Herkimer	24
Kings	2,347	Jefferson	38
Nassau	252	Lewis	6
Orange	84	Madison	22
Putnam	8	Oneida	91
Queens	790	Onondaga	157
Richmond	91	Oswego	32
Rockland	43	Otsego	20
Suffolk	115	St. Lawrence	35
Sullivan	25	Tioga	12
Ulster	36	Tompkins	25
Westchester	433	Total	604
Total	8,549	State	10,839

Table 13. Distribution of Dental Hygienists by County and District, New York State, 1942-43. 10/

County	Number	County	Number
Rochester District		Albany District	
Allegany	4	Albany	18
Chemung	11	Clinton	4
Genesee	23	Columbia	3
Livingston	8	Essex	2
Monroe	150	Franklin	6
Ontario	22	Fulton	3
Orleans	1	Greene	3
Schuyler	-	Hamilton	2
Seneca	14	Montgomery	5
Steuben	17	Rensselaer	7
Wayne	9	Saratoga	5
Wyoming	-	Schenectady	22
Yates	4	Schoharie	6
Total	263	Warren	1
Buffalo District		Washington	7
Cattaraugus	10	Total	94
Chautauqua	16	Syracuse District	
Erie	56	Broome	31
Niagara	19	Cayuga	14
Total	101	Chenango	3
New York District		Cortland	-
Bronx & New York	207	Delaware	9
Dutchess	18	Herkimer	7
Kings	204	Jefferson	16
Nassau	55	Lewis	3
Orange	11	Madison	5
Putnam	1	Oneida	35
Queens	113	Onondaga	51
Richmond	13	Oswego	14
Rockland	8	Otsego	5
Suffolk	17	St. Lawrence	7
Sullivan	8	Tioga	3
Ulster	7	Tompkins	16
Westchester	84	Total	219
Total	746	State	1,423

9/ Registered Dentists, Dental Schools and Dental Hygienists, 1941-42, New York State Department of Education.

10/ Ibid., 1942-43.

than three times the 10,839 dentists resident in New York State in 1941. Inasmuch as many dentists have the assistance of dental hygienists, the reduction in the number of dentists which could be brought about by the employment of dental hygienists for cleaning teeth and taking x-rays has been calculated. If dental hygienists did all prophylactic work and took all x-rays, they might take the place of 14,300 dentists. If they took all the x-rays and did one-half of the cleaning of teeth, they might take the place of 9,900 dentists. The number of dentists and dental hygienists by county and district is shown in Tables 12 and 13.

It is obvious that even with the utilization of dental hygienists, the present dental personnel is sufficient to implement only a very modest dental program, perhaps one beginning with children under 8 or 10 years of age. To supply complete dental care for children under 18, there would be required 3,000 dentists and, if emergency dental care only (gum treatments, extractions and partial x-rays incident to extractions, were added for persons over 18, an additional 6,400 dentists would be needed. The provision of complete dental care to children under 8 would probably require the services of 1,200 or more dentists.

Table 14. Practice Categories Among 70,417 Dentists, United States, 1940.^{11/}

Type of practice	Percentage distribution
General practice only	61.3
General, with partial specialization	33.7
Oral surgery	19.4
Orthodontia	2.2
Pedodontia	1.5
Periodontia	2.1
Prosthodontia	7.7
Radiodontia	0.8
Full time specialty	5.0
Oral surgery	1.9
Orthodontia	1.5
Pedodontia	0.3
Periodontia	0.2
Prosthodontia	1.0
Radiodontia	0.1

Dentists have not attained legal recognition of specialization corresponding to that of physicians. Although it may be assumed that dentists in New York State would tend to a greater degree of specialization than dentists throughout the country, some indication of the specialization in dentistry may be gathered from the national figures shown in Table 14.

Optometrists

Very little is known about the volume of service provided by optometrists. Although many of them work in the departments of stores, institutions, etc., and devote all of their time to the examination of eyes and the fitting of glasses, a large

^{11/} "Dental Problems in Post-War Planning," H. Strusser, Journal of the American Dental Association, 32:991, August 1945.

Table 15. Distribution of Registered Optometrists by County and District, New York State, 1944.^{12/}

County	Number	County	Number
Rochester District		Albany District	
Allegany	5	Albany	28
Chemung	10	Clinton	5
Genesee	4	Columbia	7
Livingston	5	Essex	3
Monroe	66	Franklin	7
Ontario	11	Fulton	4
Orleans	3	Greene	3
Schuyler	1	Hamilton	0
Seneca	4	Montgomery	7
Steuben	8	Rensselaer	15
Wayne	10	Saratoga	11
Wyoming	3	Schenectady	21
Yates	3	Schoharie	2
Total	133	Warren	8
Buffalo District		Washington	10
Cattaraugus	10	Total	131
Chautauqua	15	Syracuse District	
Erie	85	Broome	21
Niagara	13	Cayuga	11
Total	123	Chenango	6
New York District		Cortland	5
Bronx & New York	480	Delaware	6
Dutchess	12	Herkimer	9
Kings	295	Jefferson	9
Nassau	41	Lewis	1
Orange	25	Madison	7
Putnam	0	Oneida	28
Queens	98	Onondaga	43
Richmond	12	Oswego	4
Rockland	7	Otsego	11
Suffolk	15	St. Lawrence	11
Sullivan	4	Tioga	1
Ulster	9	Tompkins	7
Westchester	55	Total	180
Total	1,053	State	
		1,620	

number are observed to have individual places of business and to spend a part of their time in filling prescriptions for eye-glasses and providing other optical goods and services. Of the 1,726 optometrists registered in the State,^{12/} 1,620 reside in the State in the counties and districts shown in Table 15. As noted previously, the utilization of the services of optometrists in a medical care program would serve to cancel the deficiency that would exist if eye examinations were made only by physicians qualified by the American Board of Ophthalmology, or under regulations similar to those employed for Workmen's Compensation.

Nurses, except Visiting Nurses

In no other profession is it more difficult to determine the potential supply of labor than in the nursing profession. Many young women who have trained for this profession abandon it after a short period because of marriage, although they may maintain their registration and work for short periods in response to appeals in time of war, or when their individual or general economic conditions dictate. Other difficulties in judging the adequacy of the nursing force center around varying lengths of the

^{12/} Registered Optometrists, 1944-46, The New York State Education Department, Albany.

workday (8 hours or 12 hours), and varying degrees of utilization of student nurses, practical nurses, nurses' aides, attendants and orderlies in different types of hospitals and among hospitals of the same type.

Registered trained nurses. In the 1940 Census, 56,258 persons were listed as trained nurses and student nurses, of whom 53,597 were classified as employed.^{13/} It is estimated that of the latter number about 11,000 were student nurses^{14/} and 42,000 were graduate nurses. Some indication of the brief periods ordinarily worked by graduate nurses is afforded by data on their earnings in 1939.^{13/} Assuming that those earning less than \$100 were all student nurses, nearly one-half of the remainder, i.e., graduate nurses, earned less than \$1,000, which suggests that they were employed for only a fraction of the year.

In 1943, about 30,000 trained nurses and student nurses were employed

Table 16. Nurses Employed
by Hospitals, New York State,
1943.^{14/}

Type of work	Number
Employed at nursing	
Students	11,192
Graduates	15,906
Not employed at nursing	
Superintendents	130
Graduates	1,772
All students and graduates	
Total	29,970

by hospitals, as shown in Table 16. Despite the large number of trained nurses employed by hospitals, the much larger number in the labor force, and the liberal use of auxiliary personnel, many hospitals report a shortage of nurses; in fact, a number of hospital beds are not being utilized at present because of the lack of nurses. It is predicted that the current shortage will continue

for several years, until additional nurses are trained or until economic conditions provide a stimulus to many nurses to engage again in their profession.

Of the total nursing force, about 3,000 are trained nurses specially qualified for and limiting their duties to home visiting and related health instruction activities. Also, some 1,200-1,500 nurses are employed by industries for home visiting or duty in the plant, chiefly the latter.

12,196 practical nurses and midwives (the latter very few in number) were listed in the 1940 Census. Of this number, 9,957 were classified as employed. In 1943, there were 3,161 practical nurses employed by hospitals, leaving possibly as many as 9,000 available for service in the home.

^{13/} 16th Census of the United States, 1940, Third Series, The Labor Force.
^{14/} "Hospital Service in the United States," Journal of the American Medical Association, 124:839, March 25, 1944.

Table 17. Public Health Nurses in New York State, 1944.
(Exclusive of Industrial Nurses)

County	Present nurses			Standard, ratio of nurses to population			
	VNA <u>a/</u>	Public		Total	1:5000	1:3500	1:2000
		Health <u>b/</u> department	School <u>c/</u>				
Albany	18	18 <u>d/</u>	28	64	44	62	111
Allegany	0	2	12	14	8	11	20
Broome	5	8	21	34	33	46	83
Cattaraugus	0	10	4	14	15	20	36
Cayuga	2	10	9	21	13	18	33
Chautauqua	7	10	15	32	25	35	62
Chemung	5	6	7	18	15	21	37
Chenango	0	5	6	11	7	10	18
Clinton	1	4	2	7	11	15	27
Columbia	$\frac{1}{2}$	6	4	$10\frac{1}{2}$	8	12	21
Cortland	$\frac{1}{2}$	4	5	$9\frac{1}{2}$	6	9	17
Delaware	1	5	10	16	8	11	45
Dutchess	$6\frac{1}{2}$	12	13	$31\frac{1}{2}$	24	34	60
Erie	$78\frac{1}{2}$	92 <u>d/</u>	25	$195\frac{1}{2}$	160	224	399
Essex	0	2	6	8	7	10	17
Franklin	1	3	3	7	9	12	22
Fulton	$2\frac{1}{2}$	5 <u>e/</u>	9	$16\frac{1}{2}$	10	14	24
Genesee	1	3	6	10	9	12	22
Greene	0	5	2	7	6	8	14
Hamilton	0	1	0	1	1	1	2
Herkimer	2	7	8	17	12	17	30
Jefferson	5	4	12	21	17	24	42
Lewis	0	1	5	6	5	6	11
Livingston	0	5	3	8	8	11	19
Madison	0	6	6	12	8	11	20
Monroe	$41\frac{1}{2}$	81	11	$133\frac{1}{2}$	88	123	219
Montgomery	$1\frac{1}{2}$	6 <u>e/</u>	12	$19\frac{1}{2}$	12	17	30
Nassau	23	38	74	135	81	114	203
Niagara	$7\frac{1}{2}$	20	12	$39\frac{1}{2}$	32	45	80
Oneida	30	17	23	70	41	57	102
Onondaga	39	42	26	107	59	83	148
Ontario	$1\frac{1}{2}$	3	10	$14\frac{1}{2}$	11	15	28
Orange	4	13	9	26	28	39	70
Orleans	0	3	2	5	6	8	14
Oswego	$2\frac{1}{2}$	4	6	$12\frac{1}{2}$	14	20	36

Table 17, continued.

County	Present nurses			Standard, ratio of nurses to population			
	Nurse a/	Public		Total	1:5000	1:3500	1:2000
		Health b/ department	School c/				
Otsego	0	0	9	9	9	13	23
Putnam	7	0	4	11	3	5	8
Rensselaer	8	12	12	32	24	34	61
Rockland	2	0	10	12	15	21	37
St. Lawrence	1	10	0	23	18	26	46
Saratoga	3	5	7	15	13	18	33
Schenectady	12	15 f/	23	50	24	34	61
Schoharie	0	2	7	9	4	6	10
Schuyler	1 1/2	1	1	2 1/2	3	4	6
Seneca	1	4	6	11	5	7	13
Steuben	2	7	11	20	17	24	42
Suffolk	2	25	22	49	39	55	99
Sullivan	0	4	5	9	8	11	19
Tioga	0	0	4	4	5	8	14
Tompkins	0	6	7	13	8	12	21
Ulster	1	17	9	27	17	24	44
Warren	2 1/2	7	3	12 1/2	7	10	18
Washington	0	5	4	9	9	13	23
Wayne	1	4	6	13	11	15	26
Westchester	75	64	78	217	115	161	287
Wyoming	0	4	2	6	6	9	16
Yates	0	2	3	5	3	5	8
State supervisory	0	80	2	82	-	-	-
State, incl.							
N.Y. City	405	719	649	1803	1204	1690	3037
S.Y. City	350 1/2	818 d/	-	1178 1/2	1535	2196	3839
Entire State	761 1/2	1567	649	2979 1/2	2739	3886	6876

Note: Part-time nurses are assigned 1/2 value.

a/ Close of 1944, or latest fiscal year.

b/ Positions filled, December 31, 1944.

c/ As of May 1, 1944.

d/ Includes nurses employed by health departments but assigned chiefly to school work, estimated as follows: Albany 4, Erie 45, Monroe 58, Westchester 4, New York City 310.

e/ 11 nurses covering Fulton and Montgomery counties as a unit.

f/ Includes 2 nurses employed by county venereal disease control unit.

Visiting Nurses

It is estimated that for general preventive and educational service, school health service, and a small amount of bedside nursing care there should be one public health visiting nurse for each 5,000 of population; to provide the services enumerated and complete bedside nursing care of the sick in the home, there should be one public health nurse for each 2,000 of population.^{15/} Another standard that has been suggested as more immediately feasible is one nurse for each 3,500 of population. Table 17 shows the number of visiting public health nurses in each of the subdivisions of the State who are employed by health departments, visiting nurse associations and schools. The table also shows the number that should be attained to meet the three standards mentioned above. If all types of nurses are included, the standard of one nurse to 5,000 of population is met in all but Cattaraugus, Clinton, Franklin, Orange, Orleans, Oswego and Tioga counties, and New York City. 31 counties and New York City fail to meet the standard of 1:3500, although the State as a whole outside of New York City has a sufficient number. Only Putnam County meets the 1:2000 standard, although Westchester, Schenectady and a few other counties approach it. Many more nurses are needed if a standard is to be attained which will provide for adequate bedside nursing care of the sick in the home.

School nursing service and the activities of public health nurses employed by health departments have previously been discussed.

Non-official visiting nurse service. New York City and 40 counties are served by some type of non-official visiting nurse agency - see Table 18.^{16/} These may be voluntary nursing associations, insurance companies, Red Cross or other private organizations, and may provide maternity, nutrition, child health, communicable disease, tuberculosis, orthopedic, adult health, industrial, medical and surgical nursing. Some agencies also operate clinics. Most of the agencies rent or lend various types of medical equipment (e.g., crutches, bed pans, hospital beds, etc.) to patients. With the exception of insurance companies, the nursing agencies accept any patient requiring service.^{17/} They charge fees varying from \$1 to \$1.50 for the first 45 minutes or hour of the visit, with special charges for deliveries (\$5 generally), visits by appointment, physio-

^{15/} Resolutions adopted by National Organization for Public Health Nursing in June 1944, Public Health Nursing 37:3, January, 1945.

^{16/} Obtained in survey of non-official visiting nurse organizations by the Commission on Medical Care.

^{17/} However, many will not make a second visit unless a physician is in attendance.

therapy, etc.^{18/} Patients who are judged by the nurse to be unable to pay are charged only a part of the fee, or nothing. Available data^{16/19/} indicate an average of 50 per cent free patients, 10 per cent part-pay, and 40 per cent full-pay patients.^{20/}

During 1944, the 753 nurses of the 102 agencies (3 of them in New York City) made a total of 1.2 million visits, distributed as shown in Table 19. 98 per cent were home visits, the majority of them for bed patients (see Table 21.) The \$1.0 million cost of service in New York City, and \$0.89 million cost for the rest of the State was met largely through private funds, such as community chest, endowment, special drives, etc., although a significant part of the rest of the cost was met by insurance companies and patients' fees (see Table 21).

Table 21. Percentage Distribution of Visits, Cost of Service and Source of Revenue of Non-official Visiting Nurse Agencies.^{21/}

Item	New York City	Rest of State	Entire State
Visits			
Home	100	95	97
Bed	90	80	85
Other	10	15	12
Other	0	5	3
Cost of service			
Salaries	88	81	85
Nurses	75	75	75
Other	13	6	10
Maintenance	12	19	15
Source of revenue			
Patient	12	15	14
Insurance company	19	25	22
Industry	4	1	2
Public funds	2	11	6
Philanthropy	63	48	56

Table 22. Percentage Distribution of Visits by Type, for Selected Nursing Agencies^{a/}

Type of visit	Per cent of total
Non-communicable	48
Communicable	4
Maternity	
Antepartum	5
Postpartum	12
New-born	13
Health supervision	7
Not seen	8
Others	3
Total	100

a/ 27 agencies contracting with the Metropolitan Life Insurance Company to render nursing service to policyholders.

It is not possible to use the data in Table 20 to arrive at comparable cost per visit estimates since many of the agencies carry on activities

^{18/} The insurance companies which issue contracts covering home nursing service often contract with visiting nurse agencies for service. The Metropolitan Life Insurance Company, for example, contracts with 41 agencies for service. Charge for treatment of policyholders is made to the company rather than to the patient.

^{19/} Not all of the agencies were able to make these data available.

^{20/} This ratio is not entirely indicative of inability of persons to pay for visiting nurse service. Through ignorance or prejudice many persons who are able to pay fail to use the service which they consider a charity service, because formerly much of the work was done for the poor.

^{21/} Distribution of data presented in Table 19.

Table 5. Non-official Visiting Nurse Agencies in New York State in Operation in 1945.

County	City	Visiting Nurse Service of New York V. N. A. of Brooklyn V. N. A. of Staten Island	Nursing Agency
Albany	New York	Albany Cohoes Cohoes Watervliet Binghamton	Roslyn District Nursing Assoc. Port Washington Village Welfare Society. District Nursing Association of Hewlett, Woodmere, Cedarhurst, Lawrence and Inwood, Inc. Manhasset Health Center Glen Cove District Nursing Association. Women's Club of Garden City North Country Community Assoc. Great Neck Health League Metropolitan Life Insurance American Red Cross Metropolitan Life Insurance Utica Visiting Nurse and Child Health Association. V. N. A. of John Hancock Geneva Visiting Nurse Service Metropolitan Life Insurance Metropolitan Life Insurance Metropolitan Life Insurance St. Luke's Hosp., Visiting Nurse Department. Metropolitan Life Insurance John Hancock Metropolitan Life Insurance Philipstown Public Health Nursing Association Carnel District Nursing Assoc. District Nursing Association of Southeast Public Health Nursing Association of Patterson and Kent Putnam Valley Instruction District Nursing Association Metropolitan Life Insurance Metropolitan Life Insurance
Broome	Albany	Metropolitan Life Insurance John Hancock John Hancock American Red Cross Metropolitan Life Insurance Metropolitan Life Insurance Jamestown V. N. A. Visiting Nurse & TB Assn. Metropolitan Life Insurance Metropolitan Life Insurance Metropolitan Life Insurance	Lawrence Manhasset Glen Cove Garden City Glen Head Great Neck Lockport Niagara Falls Rome Utica
Cayuga	Auburn	Metropolitan Life Insurance	Onondaga
Chautauqua	Jamestown	Metropolitan Life Insurance	Ontario
Chemung	Elmira	Metropolitan Life Insurance	Orange
Clinton	Plattsburg	Metropolitan Life Insurance	
Columbia	Hudson	Metropolitan Life Insurance	
Cortland	Cortland	Metropolitan Life Insurance	
Delaware	Lake Delaware	Metropolitan Life Insurance	
Dutchess	Beacon	Metropolitan Life Insurance	
	Poughkeepsie	Poughkeepsie City & Town V. N. A. No. Dutchess Co. Community Nursing Service	
	Rhinebeck	Metropolitan Life Insurance John Hancock	
Erie	Tonawanda	Metropolitan Life Insurance	
	Lancaster	Metropolitan Life Insurance	
	Buffalo	St. Paul's Cathedral V. N. A. of Buffalo Saranac Lake Society for Control of Tuberculosis	
Franklin	Saranac Lake	Metropolitan Life Insurance	
Fulton	Gloversville	John Hancock American Red Cross Metropolitan Life Insurance Metropolitan Life Insurance Metropolitan Life Insurance Watertown V. N. A. V. N. A. Metropolitan Life Insurance John Hancock Metropolitan Life Insurance John Hancock Oyster Bay V. N. A.	
Genesee	Johnstown	Metropolitan Life Insurance	
Herkimer	Batavia	Metropolitan Life Insurance	
	Ilion	Metropolitan Life Insurance	
Jefferson	Herkimer	Metropolitan Life Insurance	
	Watertown	Metropolitan Life Insurance	
Monroe	Rochester	Metropolitan Life Insurance	
Montgomery	Amsterdam	Metropolitan Life Insurance	
Nassau	Hempstead	Metropolitan Life Insurance	
	Oyster Bay	Metropolitan Life Insurance	

Table 18. cont'd.

County	City	Nursing Agency	County	City	Nursing Agency
Saratoga	Mechanicville	Metropolitan Life Insurance John Hancock	Westchester (cont.)	Peekskill	Metropolitan Life Insurance
	Saratoga Spr.	Metropolitan Life Insurance		Tarrytown	Neighborhood House Visiting Nurse Service
Schenectady	Schenectady	John Hancock Public Health Nursing Assoc. of Schen. Co.		Scarsdale	Community Service of Scarsdale
Schuyler	Watkins Glen	Metropolitan Life Insurance		Rye	V. N. A. E. of Rye
Seneca	Seneca Falls	Metropolitan Life Insurance		Ossining	District Nursing Assoc. of Ossining
Steuben	Corning	Metropolitan Life Insurance		Port Chester	V. N. A. E. of Port Chester
	Hornell	Metropolitan Life Insurance		Mt. Vernon	V. N. A. E. of Mt. Vernon
Suffolk	Patchogue	John Hancock		Mt. Kisco	District Nursing Assoc. of Northern West. Co.
	Huntington	Metropolitan Life Insurance		New Rochelle	Visiting Nurse Assoc.
Tioga	Waverly	-----		Yonkers	Yonkers V. N. A. E.
Ulster	Kingston	Metropolitan Life Insurance		Tuckahoe	Public Health Nursing, Assoc. of Eastchester
Warren	Glens Falls	John Hancock		White Plains	White Plains Nursing Assoc.
Wayne	Newark	Women's Civic Club		Larchmont	Larchmont Public Health Nursing Association
Westchester	Felham	Metropolitan Life Insurance		Mamaroneck	Mamaroneck Health Center
	Harrison	Pelham Community Service Town of Harrison Nursing Service			

a/ Visiting Nurse Association

b/ Metropolitan Life Insurance service in Oneida discontinued in 1943 as official agency's nurses handle the work of the community at no charge.

c/ The visiting nurse agencies listed whose activities are included in Table 2. All of these organizations currently operate a visiting nurse service; some of them also carry on clinic, educational school health, etc., activities. This list is based on a survey of all non-official visiting nurse organizations listed in the 1941 National Organization for Public Health Nursing.

d/ Metropolitan Life Insurance work handled by the Poughkeepsie V. N. A.

e/ There is a visiting nurse employed by a private family, who carries on limited visiting nurse service. It was not possible to obtain any data on her activities.

f/ Metropolitan Life Insurance nursing service for Waverly is handled through a non-official nursing agency in Sayre, Pennsylvania. Note: The following organizations have public health nursing staffs which may do home visiting, but which do not give bedside care.

The Speedwell Society - New York City
Women's Branch, New York City Mission Society,
New York City
Dutchess County Health Association, Poughkeepsie
Purchase Nursing Committee - Purchase
Iola Sanitarium - Rochester
Tuberculosis and Health Association of Rochester
and Monroe County - Rochester
Oneida Co. Tuberculosis and Health Association - Rome
Syracuse Free Dispensary - Syracuse
Day Home Clinic - Troy
Rensselaer Co. Tuberculosis and Public Health
Association - Troy
American Red Cross - Mineola, Lockport, Utica
Westchester Cancer Committee - White Plains
Westchester Co. Tuberculosis and Health Association -
White Plains
Judson Health Center - New York City

Table 19 Non-official Visiting Nurse Organizations in New York State, Number of Nurses and Volume of Service in 1944.

County	No. of agencies	Type agency				Nurses rendering service ^d				Visits			
		V.N.A.	R.C.	L.I.	Other	Super-visors	Student nurse	Other	Total	Home	Bed	Other	Total
Total	3	2	-	-	-	-	50	219 ^a	358 ^a	553,025	61,627 ^f	-	614,652
East of State													
Albany	4	1	-	3	-	3	-	15	18	33,605	12,590	-	46,195
Broome	2	-	1	1	-	-	-	5	5	9,666	-	-	9,666
Cayuga	1	-	-	1	-	-	-	2	2	3,857	-	-	3,857
Chautauqua	1	1	-	-	-	1	-	6	7	12,716	1,827	641	15,184
Chemung	1	1	-	-	-	1	-	4	5	3,070	4,211	580	7,861
Clinton	1	-	-	1	-	-	-	1	1	1,526	-	-	1,526
Columbia	1	-	-	1	-	-	-	-	-	609	-	-	609
Cortland	1	-	-	1	-	-	-	-	-	1,040	-	-	1,040
Delaware ^{a/}	1	-	-	-	1 ^g	-	-	1	1	-	-	-	-
Dutchess	2	2	-	1	-	1	-	5 ^h	6 ^h	7,197	3,413	1,487	12,097
Erie	5	1	-	3	1	13	15 ^{a/}	50 ^h	78 ^h	67,775	22,367	11,790	101,932
Franklin	1	-	-	-	1	-	-	1	1	1,478	-	-	1,478
Fulton	3	-	1	2	-	-	-	2 ^h	2 ^h	3,525	658	145	4,328
Genesee	1	-	-	1	-	-	-	1	1	2,308	-	-	2,308
Herkimer	1	-	-	2	-	-	-	2	2	3,790	-	-	3,790
Jefferson	2	1	-	1	-	1	-	4	5	9,959	-	-	9,959
Monroe	1	1	-	-	-	7	-	34 ^h	41 ^h	75,036	-	-	75,036
Montgomery	2	-	-	2	-	-	-	1 ^h	1 ^h	3,073	-	-	3,073
Nassau ^{a/}	11	2	-	2	-	2	-	21	23	28,262	7,090	1,900	37,252
Niagara	2	-	1	1	-	3	-	4 ^h	7 ^h	11,561	-	-	11,561
Oneida	2	1	-	1	-	4	8	18	30	31,438	6,905	2,192	40,535
Onondaga	2	1	-	1	-	4	17	18	39	21,450	3,958	5,914	31,322
Ontario	1	1	-	-	-	-	-	1 ^h	1 ^h	1,844	261	163	2,268
Orange	1	1	-	3	-	-	-	4	4	7,265	-	-	7,265
Oswego	3	-	-	3	-	-	-	2 ^h	2 ^h	4,628	-	-	4,628
Putnam	1	1	-	-	-	-	-	7	7	5,416	2,813	397	8,626
Rensselaer	1	1	-	-	-	1	-	7	8	15,893	-	-	15,893
Rockland	1	-	-	1	-	-	-	2	2	3,819	-	-	3,819
St. Lawrence	1	-	-	1	-	-	-	1	1	2,007	-	-	2,007
Saratoga	4	-	-	4	-	-	-	3	3	4,289	-	-	4,289
Schenectady	1	1	-	-	-	2	-	10	12	14,488	4,230	217	18,935
Schuyler	1	-	-	1	-	-	-	3	3	404	-	-	404
Seneca	1	-	-	1	-	-	-	1	1	1,687	-	-	1,687
Steuben	2	-	-	2	-	-	-	2	2	2,466	-	-	2,466
Suffolk	3	-	-	3	-	-	-	2	2	2,652	-	-	2,652
Ulster	1	-	-	1	-	-	-	1	1	2,325	-	-	2,325
Warren	3	1	-	2	-	-	-	2 ^h	2 ^h	5,581	12	-	5,593
Wayne	1	-	-	1	-	-	-	1	1	1,793	-	-	1,793
Westchester ^{h/}	16	15	-	1	-	8	4	63	75	86,738	27,114	4,414	118,266
Total	99	44	3	48	3	51	44	310	415	496,236	97,449	29,840	623,525
Entire State													
Total	122	47	3	51	3	110	94	592 ^a	763 ^a	1,049,261	159,076	29,840	1,238,177

a/ Visiting Nurse Association

b/ Red Cross

c/ Life insurance company

d/ For each part-time nurses, $\frac{1}{2}$ nurse is added.

e/ There is a visiting nurse employed by a private family at Lake Delaware. However it was not possible to obtain any data on her activities.

f/ Estimated

g/ The county assigns two county nurses to local V.N.A.'s, salaries of these nurses are paid by the county; these nurses, their services and cost of services are included in activities of official

public health nurses in Chapter V

h/ The county assigns $4\frac{1}{2}$ nurses and The City of Yonkers, two nurses, to work for local VNA's. The number of nurses and cost of their services are included under activities of official public health nurses in Chapter V. However the visits made by these nurses are included in this table.

7 1e Non-official Visiting Nurse Organizations in New York State, Cost of Visits and Sources of Funds

County	Cost of service				Source of revenue					
	Salaries		Maintenance	Total	Patient	Insurance Co.	Industry	Public	Other	Total
	Nurses	Other								
New York City										
Total	\$ 785,326	\$131,712	\$130,940	\$1,047,978	\$124,821	\$196,684	\$40,337	\$ 19,693	\$ 652,598	\$1,034,123
Rest of State										
Albany	33,873	2,686	9,396	45,955	9,835	15,258	500	6,375	17,261	49,229
Broome	8,962	-	2,330	11,292	1,551	6,244	-	-	3,497	11,292
Cayuga	3,541	-	1,003	4,544	-	4,544	-	-	-	4,544
Chautauqua	12,249	1,370	1,701	15,320	3,713	1,803	-	3,263	6,794	15,573
Chemung	8,034	605	1,611	10,250	1,444	1,701	901	-	6,274	10,320
Clinton	1,593	-	344	1,937	-	1,937	-	-	-	1,937
Columbia	1,170	-	-	1,170	-	1,170	-	-	-	1,170
Cortland	1,649	-	269	1,918	-	1,918	-	-	-	1,918
Delaware ^{a/}	-	-	-	-	-	-	-	-	-	-
Dutchess	12,752	800	4,432	17,984	2,611	4,011	2,526	-	10,003	19,151
Erie	109,598	7,302	11,408	128,308	16,868	23,198	-	-	88,399	128,465
Franklin	2,066	-	-	2,066	423	-	-	-	1,643	2,066
Fulton	4,789	-	1,021	5,810	337	3,489	-	982	-	4,808
Genesee	1,795	-	356	2,151	-	2,151	-	-	-	2,151
Herkimer	3,504	-	977	4,481	-	4,481	-	-	-	4,481
Jefferson	7,221	984	3,010	11,215	514	2,775	-	1,500	6,291	11,080
Monroe	74,662	10,717	14,253	99,632	17,396	16,930	-	4,580	60,826	99,732
Montgomery	3,094	-	668	3,762	864	2,898	-	-	-	3,762
Nassau ^{b/}	51,945	2,755	18,355	73,055	4,523	31,317	2,127	741	36,188	74,896
Niagara	12,735	2,000	2,155	16,890	2,499	8,908	374	-	5,109	16,890
Oneida	39,127	3,828	9,715	52,670	7,148	7,475	-	12,592	24,967	52,182
Onondaga	32,569	3,900	113	36,582	7,657	4,499	-	2,467	27,075	41,698
Ontario	2,043	-	757	2,800	912	442	150	-	1,677	3,181
Orange	6,867	-	1,434	8,301	1,165	6,627	-	-	509	8,301
Oswego	4,068	-	848	4,916	-	4,916	-	-	-	4,916
Putnam	12,039	2,227	7,850	22,116	1,202	91	-	13,000	8,376	22,669
Rensselaer	14,123	-	4,944	19,067	3,622	6,366	-	1,500	8,050	19,538
Rockland	3,992	-	686	4,678	-	4,678	-	-	-	4,678
St. Lawrence	1,664	-	351	2,015	-	2,015	-	-	-	2,015
Saratoga	4,279	-	806	5,085	-	5,085	-	-	-	5,085
Schenectady	17,540	300	3,644	21,484	5,473	3,668	-	6,500	8,400	24,041
Schuyler	390	-	-	390	-	390	-	-	-	390
Seneca	2,189	-	462	2,651	-	2,651	-	-	-	2,651
Steuben	3,768	-	710	4,478	-	4,478	-	-	-	4,478
Suffolk	2,208	-	654	2,862	-	2,862	-	-	-	2,862
Ulster	2,163	-	334	2,497	-	2,497	-	-	-	2,497
Warren	5,345	-	539	5,884	219	3,962	-	-	1,703	5,884
Wayne	1,658	-	392	2,050	-	2,050	-	-	-	2,050
Westchester ^{c/}	137,586	12,828	55,236	205,650	43,805	18,654	178	47,504	102,342	212,483
Total	648,850	52,302	162,764	863,916	133,781	218,139	6,756	101,004	425,384	885,064
Entire State										
Total	1,434,176	184,014	293,704	1,911,894	268,602	414,823	47,093	120,697	1,077,982	1,919,197

a/ There is a visiting nurse employed by a private family at Lake Delaware. However it was not possible to obtain any data on her activities.

b/ The county assigns two county nurses to local VNA's salaries of these nurses are paid by the county; these nurses, their services, and cost of services are included in activities of official public health nurses in Chapter V

c/ The county assigns 4½ nurses and The City of Yonkers, two nurses, to work for local VNA's. The number of nurses and cost of their services are included under activities of official public health nurses in Chapter V

V However, the visits made by these nurses are included in this table.

other than home nursing; administration is not included in the costs of insurance company nursing, maintenance costs are not included for others, etc. However, average cost per visit data are available for 27 of the nursing agencies throughout the State which provide service to policyholders of the Metropolitan Life Insurance Company.^{22/} In 1944, these agencies had an average cost per visit of \$1.42 (minimum \$1.04, maximum \$1.86). The types of visits made by these agencies are shown in Table 22.

^{22/} Communication from the Metropolitan Life Insurance Company.

CHAPTER XIV

FACILITIES FOR MEDICAL CARE, CONTINUED
(GENERAL HOSPITAL AND CLINIC FACILITIES)Volume of Service Required

In determining the amount of hospital care that would be necessary for the "application of good current medical practice to all the people," use has been made of the Lee-Jones study.^{1/} In Table 1, the Lee-Jones data have been adjusted to the 1940 age distribution in New York State. Hospitalization for tuberculosis and mental disease (except minor mental disorders), and care of a custodial type, have been excluded.

Table 1. Hospitalization Required for Adequate Care, New York State.^{1/}

Disease	Days care required per 100 cases	Cases expected per 1000 pop.	Days care per 1000 population
Respiratory	24.1	419.28	101.05
Digestive	196.5	108.11	212.44
Acute communicable	380.0	51.11	194.22
Injuries	90.7	54.15	49.11
Puerperal	865.0	21.10	182.52
Venereal	255.0	24.17	61.63
General	435.8	26.63	116.05
Skin	23.1	16.03	3.70
Female genital	196.6	17.11	33.64
Ear and mastoid	60.0	10.81	6.49
Muscles, bones & joints	240.6	15.32	36.86
Kidneys and annexa	469.1	14.31	67.13
Heart & arteries	254.8	14.17	36.11
Eye & annexa	27.9	7.39	2.06
Circulatory system	21.0	6.52	1.37
Male genital	1407.9	1.15	16.19
Neuralgia, neuritis, etc.	6.0	15.44	.93
Nervous & mental	217.0	15.50	33.64
Nervous & mental	669.5	12.06	80.74
Total	-	850.36	1,235.88

According to this rate derived from Lee and Jones, for every 1,000 of population there must be provided 1,236 days of hospital care to supply adequate diagnostic and curative service. Applying this rate to the New York State population, it is found that 17 million days of hospital care would be needed.

Volume of Service Provided

It is found that the hospitals of the State, other than tuberculosis,

^{1/} The Fundamentals of Good Medical Care, R. I. Lee and L. W. Jones, Publication No. 22 of the Committee on the Costs of Medical Care, University of Chicago Press, 1933.

mental, Federal^{2/} and departments of institutions, actually provided 18.1 million days care in 1944, the latest year for which complete figures are available (18.0 million in 1943). This figure exceeds by 1 million days the amount considered adequate by the Lee-Cross Study, which was based upon good medical practice of the period around 1930. One factor may be that many non-residents come to New York, especially to New York City, for hospital care. It is difficult to estimate the extent of this practice, but it would probably account for at least 1 million days, so that 17 million days would be the utilization rate for State residents. (It has been necessary in previous calculations, and is here necessary to assume that about 1 million persons living out of the State but adjacent to New York City, and perhaps working in New York City, would turn to the physicians, dentists, hospitals, etc. of that community for medical care).

In 1930 there was provided 14 million days of care, in contrast with the 17 million needed. If it is assumed that there has been an upward trend in the need for hospital care from 1930 to 1944, corresponding exactly to the trend in care actually provided, the rate adjusted to 1944 would require more than 22 million days. However, such an assumption does not seem justifiable. It would be expected that the amount of care actually furnished would increase more rapidly than the amount of care needed because, as additional facilities have been provided^{3/} and as the social welfare medical program has expanded, the two greatest barriers to hospitalization, lack of facilities and inability to pay, have been largely removed. It is probable that the present extent of hospitalization approximates very closely that which is needed. It therefore does not seem likely that there would be a greatly increased demand for general hospital care if the economic barrier were removed.

Effect of hospital insurance. It is commonly believed that enrollment under Blue Cross plans increases the demand for hospital care. Table 2 shows the hospital days per 1,000 persons of all ages and sexes covered by Blue Cross plans in New York State in 1943.^{4/} Only 12.1 million days would be required if the entire State population used hospitals at the

^{2/} Veterans' general hospitals in New York State provided 735,840 days care to residents and non-residents in 1944. The average stay was in excess of 50 days. This and other types of Federal care have been excluded from these calculations because they are national rather than a State or local responsibility.

^{3/} Non-Federal "general" hospital beds increased from 41,900 in 1930 to 67,164 in 1944.

^{4/} These and subsequent data referring to Blue Cross plans are taken from Experience of Blue Cross Hospital Service Plans, 1943, Hospital Service Plan Commission, American Hospital Association, Chicago.

Table 2. Hospital Days That Would Be Required in New York State,
According to Blue Cross Experience.^{4/}

Blue Cross plan area	Days per 1000 population	Population	Expected days hospitalization
New York	910	9,366,915	8,523,893
Rochester	730	547,574	427,108
Syracuse	730	849,048	619,805
Buffalo	860	1,238,931	1,065,481
Albany	930	755,103	702,246
Geneva	910	94,146	85,673
Jamestown	730	122,627	89,518
Watertown	820	83,176	68,204
Utica	a/	695,198	570,062
Total	-	13,752,718	12,151,990

a/ Figure not available; Watertown rate employed.

same rate as the persons covered by Blue Cross plans. The reasons for this difference may be that the Blue Cross group is select, because usually at least one person in the family covered by the contract is employed and has a financial incentive to work rather than to enter a hospital. Further, many employed persons have passed pre-employment physical examinations and have been found fit. Also, the Blue Cross group is economically well-favored, being able to pay premiums and supposedly being in a position to afford the privately purchased preventive medical services and to enjoy the relatively high standard of living which are associated with low disease rates.

On the other hand, because of its superior economic status the Blue Cross group, which in New York State is covered almost wholly by semi-private contracts, might be expected to use more hospitalization than poorer (i.e., ward-plan) groups because of luxury demand. However, Table 3, which is based upon the experience of plans (all out-of-State) where

Table 3. Hospital Utilization ^{a/} Under Blue Cross Plans, According to Type of Coverage ^{4/}

Type of contract	Admissions per 1,000 persons		Days care per 1,000 persons		Average length of stay	
	Ward	Semi-priv.	Ward	Semi-priv.	Ward	Semi-priv.
One person	84	95	753	1,039	9.14	8.99
Two persons	87	120	776	1,010	9.66	9.68
Family	76	97	517	637	6.61	6.62
All types	77	100	564	784	-	-

a/ Figures are medians.

both ward and semi-private contracts are written by the same plans, indicates that poorer insured persons use less hospital care than the relatively well-to-do, not because they stay in the hospital a shorter time, but because they enter the hospital less frequently. Two reasons are suggested

for this difference. First, the poorer group is not anxious to be hospitalized, either because the wage earner would lose time from work, or because there would be inability to pay for the services of someone to carry on at home if the wife or mother were hospitalized. However, this does not seem to have been true, because even the children under ward contracts were admitted less frequently (ward 56, semi-private 76 per 1000). The second and more likely reason is the circumstances governing admissions. The semi-private patient has his own physician and it is probable that the patient's wishes influence the physician in some degree to obtain admission of his patient to the hospital. In the case of the ward patient, it is usually the hospital staff rather than the private physician who admits the patient, the decision being based more on need for hospital care than on the patient's wishes. It would seem likely that when a patient is able to make his wishes felt to some extent through a physician whom he is paying, there is a greater hospital utilization than when hospital care is provided on the basis of need determined by a physician not paid directly by the patient.

Although it may be inferred from the growth of hospital facilities in the State and the adequacy of the social welfare program that the present extent of hospitalization closely approximates that which is needed, to allow for some increase in utilization provision should be made for about 20 million hospital days annually over a period of the next few years, 19 million days for residents and 1 million days for non-residents. This figure probably is a maximum since, as mentioned previously, veterans hospitals will take up much of the increased demand of the future. To provide 20 million days care there would be required 60,500 beds, utilized at an average capacity of 80 per cent.

Existing Facilities and Utilization

Hospital districts. Patients tend to gravitate toward centers of population for hospital care, since it is there that hospitals offer more highly specialized facilities and it is in these centers that specialized physicians practice. Accordingly, the need for hospital facilities is more fairly appraised on the basis of districts about such centers than by individual counties. This is also generally true of physicians' services, dentists' services, etc., and such districts have been employed in studies of other medical care facilities. From a study of districts in the State which have been established for State administrative pur-

poses,^{5/} marketing areas,^{6/} and from a general knowledge of lines of travel, etc., the State was divided into 5 districts centering around Buffalo, Rochester, Syracuse, Albany and New York City (see Figure 1). Each of these cities is a center of hospitalization for the surrounding area and each contains one or more schools of medicine. Similar areas or districts differing slightly from those used in this study have been suggested by the State Health Preparedness Commission (Figure 2), and the United States Public Health Service (Figure 3), as a basis for the regional development of an integrated system of hospital and related facilities.

Table 4. Population of Hospital Districts, 1944 and 1945.

District	Population ^{a/}	
	1944	1945
Albany	948,609	939,558
Buffalo	1,154,719	1,221,629
Rochester	941,847	945,671
Syracuse	1,324,922	1,337,233
New York	9,109,045	9,315,358
State	13,479,142	13,759,449

^{a/} From reports of the New York State Department of Health.

The population of the districts employed in this study is shown in Table 4. In some cases the 1944 figures have been used, and in others the 1945 figures, depending upon when the calculations were made.

Number and type of

beds. The State has 67,164 general hospital beds distributed as shown in Table 5, which also shows the average census and annual admissions. This number is 4.88 beds per 1,000 population (or, if 1 million is added to the State's population to correct for the use of hospital facilities by non-residents, the figure is 4.55 beds per 1,000 population). The various types of hospitals, with the total number of beds, are shown in Table 6 for the districts of the State. In a distribution of hospitals according to bed capacity, it is found that 20 per cent of the hospitals have a capacity of less than 25 beds and nearly 60 per cent are smaller than 100 beds. Only 28 per cent possess as many as 150 beds, which is about the minimum for efficiency and economy of operation.

Complete data were not obtained in respect to a division between private rooms (i.e., rooms with only 1 bed), and other less private facilities. The distinction between private, semi-private and ward hospital beds depends upon two variables: the number of beds in the room, and whether a private physician or a staff physician is in attendance. Thus it is possible for two patients to occupy the same 2-bed room, of whom one is a

^{5/} Public Health, Social Welfare, Labor, Mental Hygiene, Conservation, Public Works, Taxation and Finance, Tuberculosis Hospitals, etc.

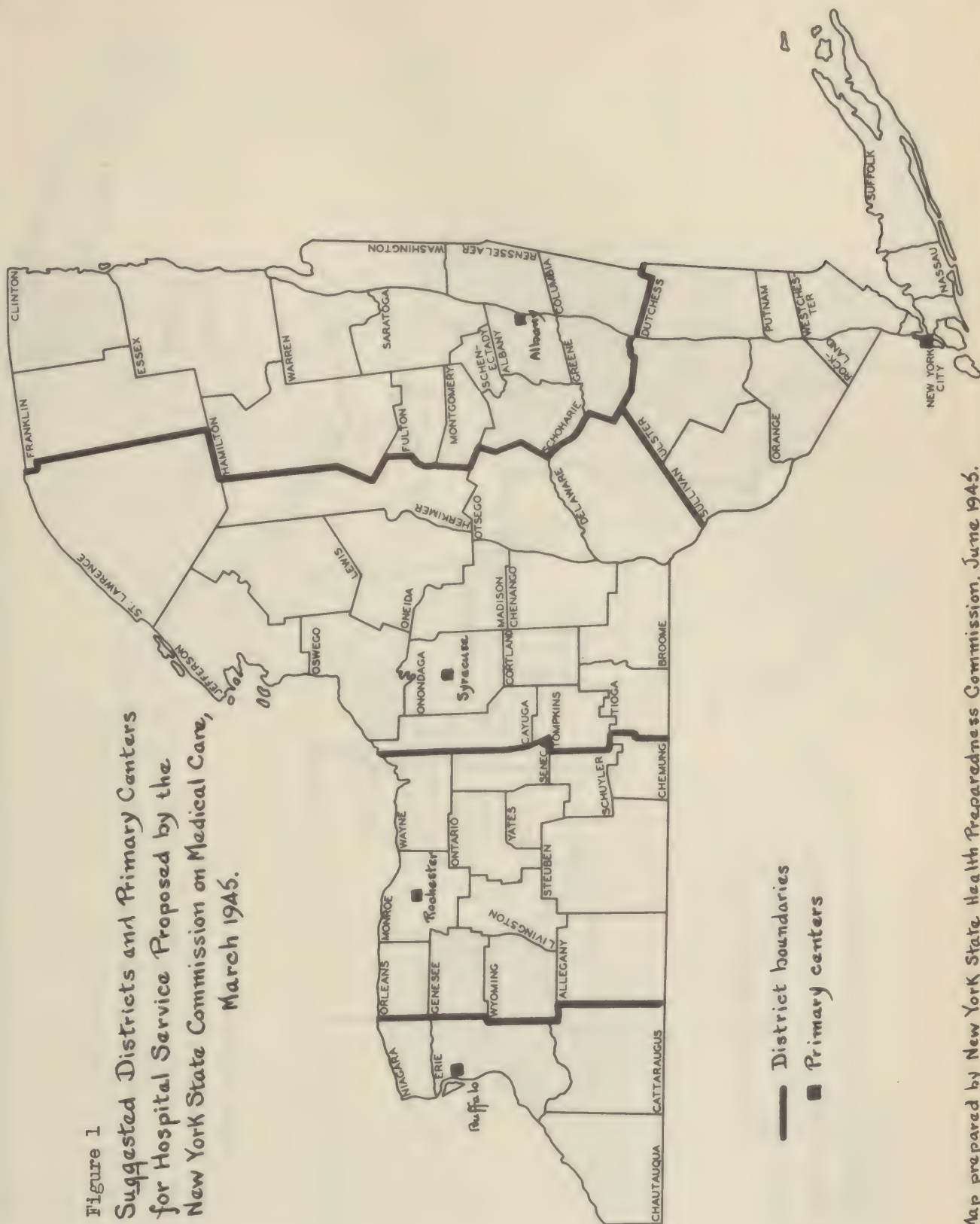
^{6/} Marketing Map of New York, Marketing Division, Hearst Magazine, Inc., New York, 1942.

Table 5. General Hospitals of New York State, 1944, by County and District. Based on Data from American Medical Association, State Departments of Health and Social Welfare, and Commission Studies. Includes Maternity Homes and Convalescent Hospitals. Excludes Federal, Tuberculosis and Mental Hospitals, and Department of Institutions.

County	Hospitals	Number of beds	Average census	Admissions
Albany District				
Albany	8	1,189	1,019	24,579
Clinton	2	191	149	5,976
Columbia	2	135	105	4,301
Essex	7	122	71	2,010
Franklin	4	222	162	3,674
Fulton	1	133	110	4,881
Greene	1	70	59	1,840
Hamilton	0	--	--	--
Montgomery	2	239	193	5,693
Rensselaer	6	633	431	12,497
Saratoga	3	133	82	3,002
Schenectady	4	525	364	14,057
Schoharie	2	9	4	174
Warren	1	120	113	3,971
Washington	4	124	72	1,352
Total	47	3,845	2,934	88,007
Syracuse District				
Broome	6	1,024	689	20,636
Cayuga	3	307	261	8,892
Chenango	7	138	78	2,572
Cortland	2	143	103	3,411
Delaware	9	131	72	3,132
Herkimer	3	190	138	5,924
Jefferson	8	412	287	8,583
Lewis	1	44	32	1,062
Madison	5	130	93	3,649
Oneida	10	1,098	829	24,461
Onondaga	11	1,227	930	25,589
Oswego	2	150	106	3,331
Otsego	4	199	122	4,187
St. Lawrence	8	371	284	8,613
Tioga	1	67	56	1,792
Tompkins	3	261	192	3,825
Total	83	5,892	4,272	133,059
Buffalo District				
Cattaraugus	6	289	185	7,476
Chautauqua	6	396	299	11,402
Erie	21	3,727	2,995	78,238
Niagara	5	588	474	18,867
Total	38	5,000	3,953	115,983
Rochester District				
Allegany	3	94	64	2,758
Chemung	2	436	348	11,292
Genesee	3	144	117	4,362
Livingston	2	55	25	1,143
Monroe	13	2,500	1,962	50,427
Ontario	3	497	288	8,226
Orleans	3	107	62	1,897
Schuyler	1	36	23	758
Seneca	2	55	38	1,177
Steuben	5	328	195	10,830
Wayne	4	99	63	2,104
Wyoming	3	184	117	2,655
Yates	1	50	29	1,120
Total	45	5,585	3,331	98,749
New York District				
Bronx & New York	91	25,825	19,194	449,433
Dutchess	5	471	381	10,030
Kings	49	10,855	7,892	221,592
Nassau	12	1,063	857	25,223
Orange	8	572	375	12,400
Putnam	2	56	23	743
Queens	20	2,520	1,944	64,864
Richmond	6	827	532	13,719
Rockland	4	508	261	5,019
Suffolk	11	1,016	690	14,631
Sullivan	5	112	69	2,348
Ulster	5	271	205	6,796
Westchester	24	3,746	2,675	60,661
Total	242	47,842	35,098	887,459
Entire State				
Total	455	67,164	49,588	1,323,857

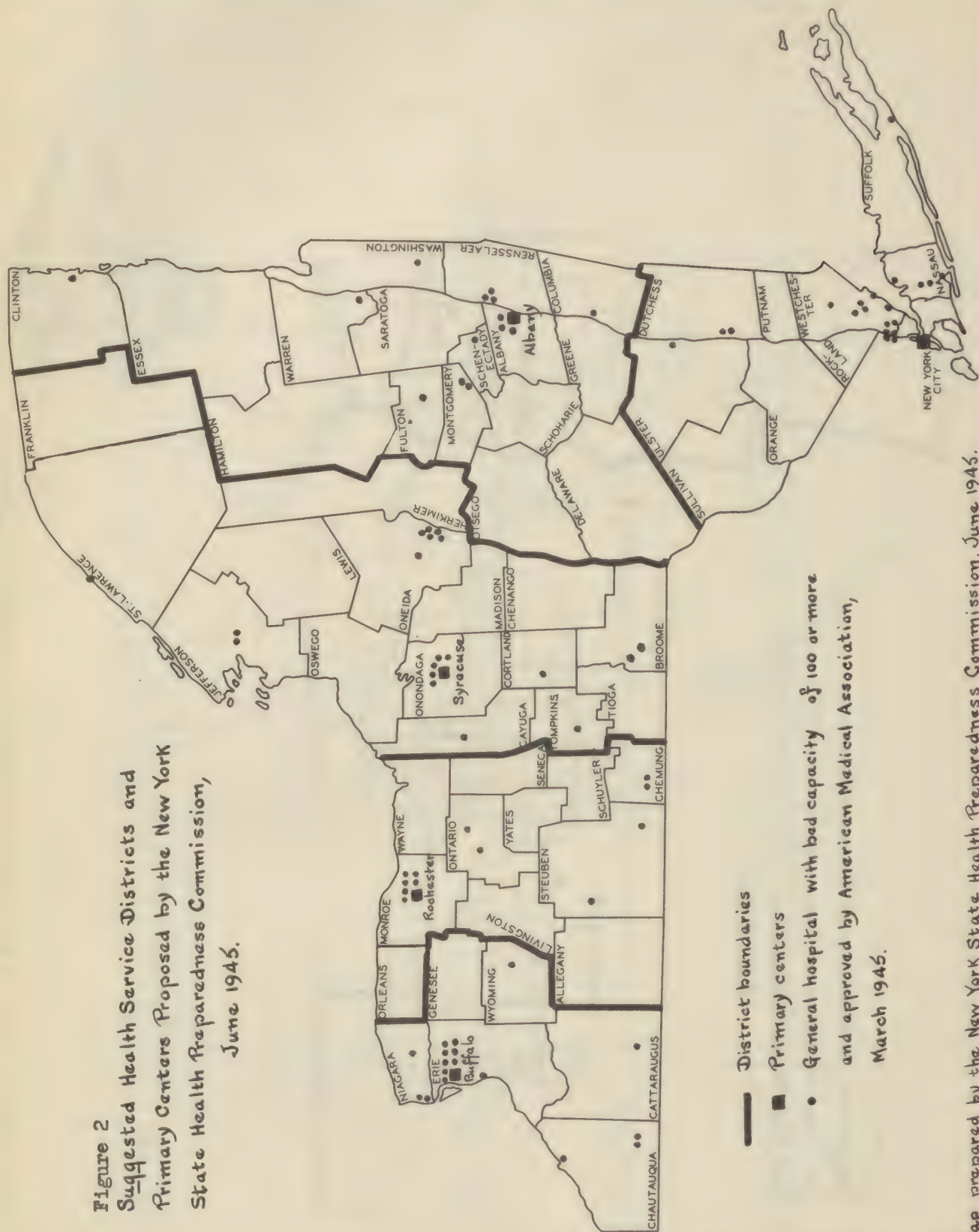
Figure 1

Suggested Districts and Primary Centers
for Hospital Service Proposed by the
New York State Commission on Medical Care,
March 1945.



Map prepared by New York State Health Preparedness Commission, June 1945.

Figure 2
Suggested Health Service Districts and
Primary Centers Proposed by the New York
State Health Preparedness Commission,
June 1945.



Map prepared by the New York State Health Preparedness Commission, June 1945.

Table 6. Distribution of General Hospitals (Including Maternity Homes), Beds, and Average Size, by District, New York State, 1944.

Beds, and Average Size, by District, New York State, 1914.						
Hospital data	District					Entire State
	Albany	Buffalo	Rochester	Syracuse	New York	
Maternity homes, exclusively						
Number of hospitals	6	2	0	10	4	22
Number of hospital beds	71	8	0	23	142	244
Average beds per hospital	12	4	0	2	36	11
Proprietary (except maternity homes exclusively)						
Number of hospitals	4	4	14	22	61	105
Number of hospital beds	97	96	433	336	3808	4770
Average beds per hospital	24	24	31	15	62	45
Public						
Number of hospitals	4	7	5	13	23	52
Number of hospital beds	137	1635	752	1390	15,636	19,550
Average beds per hospital	34	234	150	107	680	376
Voluntary						
Number of hospitals	33	25	26	38	154	276
Number of hospital beds	3540	3261	3400	4135	28,211	42,547
Average beds per hospital	107	130	131	109	183	154
All hospitals						
Number of hospitals	47	38	45	83	242	455
Number of hospital beds	3845	5000	4585	5884	47,797	67,111
Average beds per hospital	82	132	102	71	198	148

ward (or staff) patient, and the other is a private patient. Where a room containing 2 or more beds is occupied by a patient who has his own private physician, he is usually termed a semi-private patient. However, in some hospitals a patient may occupy a bed in a room with many other patients (as in some of the Buffalo hospitals) and be termed a ward patient although he has, and is paying, his own private physician. It is suggested that hospitals in the future make a more clear distinction, e.g., private patient in single room, private patient in 2 or 4-bed room, private patient in room of more than 4 beds; staff patient in 2 or 4-bed room, staff patient in room of more than 4 beds, etc.

With the consent of the individual hospitals, the State and New York

City Health Departments made available data for a majority of the hospitals which provide care on a cost basis under the Federal Emergency Maternity and Infant Care Program. Nearly all of these hospitals fall into the category of voluntary hospitals. For New York City, they represent somewhat more than one-half of the voluntary hospitals, and in the rest of the State nearly all of the voluntary hospitals are covered. For the purposes of these calculations, it has been assumed that in the maternity homes and proprietary hospitals, nearly all of the facilities are 1-bed rooms, while in the public hospitals nearly all of the facilities are rooms of 2 or more beds. Table 7 summarizes the data concerning bed capacity of rooms in hospitals for which these data were available. About one-fifth of the voluntary hospital beds are in private, 1-bed rooms, the percentage varying from 18.4 in suburban New York to 31.2 in the Rochester district. The percentage of hospital days according to bed capacity of the rooms corresponds closely to the types of room.

Table 7. Beds and Hospital Days in "Voluntary" Hospitals^{a/} According to Bed Capacity of Room, New York State, 1945.

District	Hospitals	Hospital beds			Hospital days		
		Number	Per cent in rooms		Number (thousands)	Per cent in rooms	
			One bed	2 or more		One bed	2 or more
Albany	25	3,047	22.8	77.2	824	23.3	76.7
Buffalo	23	3,292	26.4	73.6	967	26.1	73.9
Rochester	32	3,546	31.2	68.8	899	30.4	69.6
Syracuse	41	4,902	22.3	77.7	1,274	24.0	76.0
New York City	59	15,361	18.4	81.6	4,068	18.1	81.9
Remainder	45	4,324	21.9	78.1	1,360	17.1	82.9
Entire State	225	34,472	21.8	78.2	9,392	21.1	78.9

^{a/} Chiefly voluntary, see text.

Ancillary services. The EMIC data were also analyzed in respect to the services included by general hospitals in their total service to patients in addition to bed and board, as shown in Table 8. Outside of New York City only a few of the larger hospitals (although with from 30 to 50 per cent of all beds) provide social service. In the Albany and Buffalo districts 21 and 15 per cent of the bed capacity does not include x-ray service, and in both the Albany and Rochester districts, 25 per cent of bed capacity does not include laboratory service. The failure to provide these extra services as a part of the general activities of the hospital is in some instances due to an insistence on the part of local physicians to keep such services in their own hands. It is, however, probably more closely related to the small size of many of the hospitals outside of New

Table 8. Number and Percentage of "Voluntary" Hospitals^{a/} and Hospital Beds Providing Indicated Service

District	Social service		X-ray		Laboratory	
	Hosp-itals	Beds	Hosp-itals	Beds	Hosp-itals	Beds
	Number					
Albany	5	1,162	15	2,415	15	2,299
Buffalo	4	1,050	19	2,813	19	2,926
Rochester	4	1,556	23	3,321	18	2,677
Syracuse	5	1,740	38	4,843	32	4,322
New York City	38	12,945	54	14,949	56	15,090
Remainder	13	2,162	39	4,137	37	3,903
Entire State	69	20,615	188	32,478	177	31,217
	Per cent					
Albany	20	38	60	79	60	75
Buffalo	17	32	83	85	83	89
Rochester	13	44	72	94	56	75
Syracuse	12	35	93	99	78	88
New York City	64	84	92	97	95	98
Remainder	29	50	87	96	82	90
Entire State	31	60	84	94	79	91

^{a/} Chiefly voluntary.

York City, and indicates the need for regional affiliations of hospitals in order that the smaller ones may benefit from an integrated service applying to all. This would seem to be equally true of consultation and other specialized professional services.

Utilization data. As shown in Table 9, in the State as a whole about 1 of every 11 persons is hospitalized in the course of a year. At any

Table 9. General Hospital Utilization Data for Residents of New York State, 1944.

District	Per 1,000 of population				Average length of stay
	Beds	Admissions	No. confined	Days per year	
Albany	4.09	93.7	3.1	1,140	12.2
Buffalo	4.09	94.9	3.2	1,181	12.4
Rochester	4.85	104.4	3.5	1,286	12.3
Syracuse	4.40	100.0	3.2	1,166	11.7
New York ^{a/}	4.63	87.6	3.4	1,242	14.4
State ^{a/}	4.55	89.7	3.3	1,205	13.7
^{a/} Figures adjusted by adding 1 million to population base. ^{8/} If no such adjustment is made, figures are:					
New York	5.13	95.3	3.8	1,375	14.4
State	4.88	96.2	3.6	1,315	13.7

given time, one of every 300 persons is confined to a general hospital.

The average length of stay per case is from 12 to 14 days, and the average hospital utilization per person per year is about 1.2 or 1.3 days.

^{8/} Adjustment differs slightly from earlier method of deducting 1 million days care as being for non-residents. This adjustment deducts 1 million from the population figures for New York City and the entire State, to permit calculation of admission rates.

Whether or not an adjustment^{8/} is made for hospitalization of non-residents, as indicated in Table 9, the outstanding differences between the districts are an admission rate significantly above average in the Rochester district, and an average length of stay significantly above average in the New York City district. If it is assumed that the 1,236 days per 1,000 population (i.e., about 17 million days for the State) calculated from the Lee-Jones data represents adequate care, it is found, as shown in Table 10, that only the Rochester and New York City districts now provide an adequate amount of hospital care.

Table 10. Estimated Adequacy of Hospital Care, by District.

District	Per cent adequacy
Albany	92.2
Buffalo	95.5
Rochester	104.0
Syracuse	94.3
New York ^{a/}	100.5
State ^{a/}	97.5

^{a/} Adjusted figures, see Table 9.

1.38 days per person per year (19 million days for residents of the State), and the respective deficiencies. Most of the counties show deficits, but

Table 12. Additional Hospital Beds Needed for Adequate Care.

District	Standard, days per person	
	1.24	1.38
Albany	252	735
Buffalo	--	577
Rochester	--	--
Syracuse	--	494
New York ^{a/}	--	--
State ^{a/}	252	1,806

^{a/} Adjusted figures, see Table 9.

these are largely cancelled by surpluses in heavily populated areas. Table 12 summarizes the need for additional beds, according to the standards employed. According to the present standard of 1.24 days per person, only the Albany district needs additional beds. However, if there is employed the higher standard of 1.38 days per person, such as might be expected if the economic barrier to hospitalization were largely removed, a minimum of 1,800 additional beds would be needed. Perhaps this figure would be greater if an attempt were made to correct maldistributions that may exist within the districts defined. The answer to this question would seem to be within the province of the New York State Post-War Public Works Planning Commission, which is undertaking a comprehensive study of hospital facilities (see section on Federal aid for hospital construction, this chapter).

Up to this point it has been assumed that existing hospital facili-

Deficiencies in hospital beds.

Table 11 shows for each county and district the existing number of beds and the number needed if there is to be provided 1.24 days hospital care per person per year (17 million days for residents of the State), and

these are largely cancelled by surpluses in heavily populated areas. Table 12 summarizes the need for additional beds, according to the standards employed. According to the present standard of 1.24 days per person, only the Albany district needs additional beds. However, if there is employed the higher standard of 1.38 days per person, such as

Table 11. Distribution of General Hospital Beds by County and by Hospital District, Together With Estimate of Beds Needed and Deficit or Surplus, for Provision of 17 Million and 19 Million Days Care, Respectively. Based on 1944 Figures.

County	17 million days care				19 million days care			
	Beds have	Beds needed	Deficit or surplus		Beds have	Beds needed	Deficit or surplus	
Albany District								
Albany	1,189	957	+ 232	1,069	1,189	957	+ 232	1,069
Clinton	191	234	- 43	262	191	234	- 43	262
Columbia	135	178	- 43	199	135	178	- 43	199
Essex	122	147	- 25	165	122	147	- 25	165
Franklin	222	191	+ 31	214	222	191	+ 31	214
Fulton	133	212	- 79	236	133	212	- 79	236
Greene	70	121	- 51	135	70	121	- 51	135
Hamilton	0	17	- 17	19	0	17	- 17	19
Montgomery	239	256	- 17	285	239	256	- 17	285
Rensselaer	633	525	+ 108	588	633	525	+ 108	588
Saratoga	133	282	- 149	316	133	282	- 149	316
Schenectady	525	530	- 5	592	525	530	- 5	592
Schoharie	9	91	- 82	101	9	91	- 82	101
Warren	120	155	- 35	174	120	155	- 35	174
Washington	124	201	- 77	225	124	201	- 77	225
Total	3,845	4,097	- 252	4,580	3,845	4,097	- 252	4,580
Syracuse District								
Broome	1,024	716	+ 308	800	1,024	716	+ 308	800
Cayuga	307	282	+ 25	316	307	282	+ 25	316
Chenango	138	157	- 19	176	138	157	- 19	176
Cortland	143	144	- 1	162	143	144	- 1	162
Delaware	131	178	- 47	198	131	178	- 47	198
Herkimer	190	256	- 66	286	190	256	- 66	286
Jefferson	412	363	+ 49	406	412	363	+ 49	406
Lewis	44	98	- 54	109	44	98	- 54	109
Madison	130	167	- 37	186	130	167	- 37	186
Oneida	1,098	880	+ 218	983	1,098	880	+ 218	983
Onondaga	1,227	1,275	- 48	1,424	1,227	1,275	- 48	1,424
Oswego	150	308	- 158	343	150	308	- 158	343
Otsego	199	199	0	223	199	199	0	223
St. Lawrence	371	394	- 23	440	371	394	- 23	440
Tioga	67	117	- 50	130	67	117	- 50	130
Tompkins	261	183	+ 78	204	261	183	+ 78	204
Total	5,892	5,717	+ 175	6,386	5,892	5,717	+ 175	6,386
Buffalo District								
Cattaraugus	289	314	- 25	351	289	314	- 25	351
Chautauqua	396	534	- 138	597	396	534	- 138	597
Erie	3,727	3,450	+ 277	3,856	3,727	3,450	+ 277	3,856
Niagara	588	691	- 103	773	588	691	- 103	773
Total	5,000	4,989	+ 11	5,577	5,000	4,989	+ 11	5,577
New York City District								
Bronx & New York	25,825	14,194	+ 11,631	15,864	25,825	14,194	+ 11,631	15,864
Dutchess	471	520	- 49	582	471	520	- 49	582
Kings	10,855	11,662	- 807	13,034	10,855	11,662	- 807	13,034
Nassau	1,063	1,757	- 694	1,964	1,063	1,757	- 694	1,964
Orange	572	604	- 32	676	572	604	- 32	676
Putnam	56	72	- 16	80	56	72	- 16	80
Queens	2,520	5,607	- 3,087	6,267	2,520	5,607	- 3,087	6,267
Richmond	827	753	+ 74	842	827	753	+ 74	842
Rockland	508	321	+ 187	359	508	321	+ 187	359
Suffolk	1,016	853	+ 163	953	1,016	853	+ 163	953
Sullivan	112	163	- 51	182	112	163	- 51	182
Ulster	271	376	- 105	420	271	376	- 105	420
Westchester	2,746	2,478	+ 1,268	2,770	2,746	2,478	+ 1,268	2,770
Total	47,842	39,360	+ 8,482	43,993	47,842	39,360	+ 8,482	43,993
Adjusted totals	-	-	+ 5,058	-	-	-	+ 5,058	-

of 3,424 beds have been deducted as providing 1 million days non-resident care.

ties will be occupied at an average of 80 per cent of capacity. That this average is not uniformly maintained among hospitals is illustrated in Table 13, which shows the percentage distribution of hospitals within the several districts, according to average occupancy rates. The distributions are roughly similar for all districts. It is noted that although 30 per cent of hospitals are crowded in the sense that they are occupied at more than the 80 per cent average capacity considered to be the maximum consistent with good care, 40 per cent have an average occupancy of less than 60 per cent and thus are not being used to full advantage.

Table 13. Percentage Distribution of Hospitals by Annual Average Occupancy Rate, According to Hospital Districts, New York State, 1944.

Percentage occupancy	Buffalo	Rochester	Syracuse	Albany	New York	Entire State
100 & over	2.6	0	4.8	4.3	2.1	2.5
90-99	13.2	4.4	8.4	10.5	8.7	8.6
80-89	23.7	26.7	13.3	14.9	17.3	18.0
70-79	26.3	24.4	13.2	14.9	29.3	24.2
60-69	10.5	6.7	14.5	17.0	21.5	17.4
50-59	10.5	17.8	15.7	19.2	9.1	12.3
40-49	2.7	4.4	7.2	10.6	4.1	5.3
Under 40	10.5	15.6	22.9	8.5	7.9	11.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

The factors underlying the uneven occupancy rates undoubtedly include: unfavorable location, some decrease in the use of public hospitals during the current period of economic prosperity (although study shows this factor is not as important as might be assumed), and a growing demand for semi-private rather than ward accommodations, which may be attributed to the recently increased purchasing power and the growth of hospitalization insurance. Also, there is probably a fashion in hospitals as in other things, patients tending to prefer the newer, better equipped hospitals and those associated with the more renowned or fashionable physicians.

A more uniform utilization might be brought about in several ways. First, remodeling or new construction should be undertaken to meet the demand for private and semi-private beds rather than wards. Second, some municipalities which are maintaining isolation or other hospitals that operate far below an efficient capacity might sell or lease them to, or contract to have service provided by, non-profit organizations whose sponsorship will remove the stigma of charity and inferior service that many public hospitals now bear (sometimes justly and sometimes unjustly). Third, the voluntary affiliation of certain of the smaller hospitals with larger ones, or the outright acquisition of the former by the latter, would result in better staff work and better professional service in the small

hospitals, which would make them more attractive to patients. On the whole, New York State's hospital facilities are sufficient to meet the present needs of the people, but certain quantitative and qualitative maldistributions should be corrected during the next few years. The proposed system of Federal aid for hospital construction which is described in a subsequent section, should be of material assistance.

The cost of hospital service. In Chapter IX the per diem cost of hospital service in 1942 was found to be \$5.62 for public and \$7.61 for

Table 14. Average Per Diem Cost of Care in "Voluntary" Hospitals,^{a/} New York State, 1945^{c/}.

District	In-patients	Out-patients ^{b/}	Total
Albany	\$6.84	\$0.20	\$ 7.04
Buffalo	7.22	1.03	8.25
Rochester	7.50	0.29	7.79
Syracuse	6.66	0.13	6.79
New York City	8.58	1.24	9.82
Remainder	8.42	0.42	8.84
Entire State	7.90	0.67	8.57
State, excluding New York City	7.37	0.21	7.58

a/ See Footnote, Table 7.

b/ Added cost of out-patient service, on basis of in-patient days.

c/ Care of new-born infants included in gross per diem.

private general hospitals of all types, and \$5.69 for public and \$7.89 for private general hospitals exclusive of orthopedic, isolation and similar types. 1945 figures obtained in the study of EMIC hospital data, are presented in Table 14.

The 1945 figure corresponding to \$7.89 in 1942 is \$8.57, an increase of 8.5 per cent. In considering the cost of hospi-

tal service it is necessary to separate out-patient from in-patient costs, as is done in Table 14, since the amount of out-patient service varies considerably, and is not properly chargeable to in-patients. The in-patient costs vary considerably, from \$6.66 in the Syracuse District to \$8.58 in New York City, with a State average of \$7.90. The variation may be related in part to different content of service, e.g., the New York City hospitals were shown in Table 8 to have included more than the average amount of social service, x-ray and laboratory service. Basic differences in the costs of labor and supplies probably account for most of the remaining differences.

The differences in per diem costs among hospitals are even more striking than the differences between districts. Table 15 shows the percentage distribution of hospitals according to gross per diem rate and the rate after adjustment is made for type of beds, as described in the next paragraph. The great variation from the average, which is present within

Table 15. Distribution of Selected Hospitals by Per Diem In-Patient Cost, 1945.

Cost	No. of hospitals	
	Gross rate ^{a/}	Adjusted rate
Under \$4.50	1.2	2.8
4.50-5.24	2.4	3.6
5.25-5.99	2.0	8.0
6.00-6.74	8.0	20.4
6.75-7.49	21.2	16.4
7.50-8.24	16.0	16.8
8.25-8.99	16.0	11.2
9.00-9.74	12.4	8.4
9.75-10.49	5.6	4.8
10.50-11.24	6.4	2.4
11.25-11.99	3.2	2.4
12 or more	5.6	2.8
All	100.	100.

^{a/} Average, \$7.90

Table 16. Calculation of Per Diem Cost Under EMIC^{2/}

Per cent patient-days in rooms with 2 or more beds	Per cent of total per diem cost allowed
100-99	100
98-97	99
96-95	98
94-93	97
92-91	96
90-89	95
88-87	94
86-85	93
84-83	92
82-81	91
80-79	90
78-77	89
76-75	88
74-73	87
72-71	86
70 or less	85

the districts as well as in the State as a whole, no doubt reflects many factors - efficiency and economy of operation, services offered, cost of equipment, etc.

The gross per diem rates represent total costs, including the operation of the most luxurious accommodations. In deriving a rate for payment to hospitals under the EMIC program, costs are adjusted on the basis of the formula shown in Table 16. For example, if a hospital's gross per diem in-patient cost were \$8.00, and 79 per cent of patient days were in rooms with two or more beds, the rate of payment to the hospital would be 90 per cent of \$8.00, or a rate of \$7.20. In addition, there is a ceiling of \$8.25 on payments (except in the case of teaching hospitals, where the ceiling is \$9.00).

Federal Aid for Hospital Construction

It has been pointed out that although New York State may have an adequate number of hospital beds, they may not be properly placed and many of the existing hospital facilities are in need of replacement or improvement. During the 1930s and during the war years, both new construction and hospital maintenance were greatly retarded. In addition, many communities do not have sufficient resources, public or private, to meet the cost of hospital construction.

^{2/} EMIC Memorandum No. 3.

In recognition of a similar situation throughout the country, there was introduced in Congress the Hill-Burton Hospital Survey and Construction Bill, S. 191, which after lengthy hearings and amendment was passed in the Senate December 11, 1945 and is now pending before the Committee on Interstate and Foreign Commerce in the House. The bill has received wide support, including that of the American Medical Association and all of the hospital associations. Concerning the bill, Senator Lister Hill has stated:^{10/}

Nongovernmental hospitals ordinarily can look to no source of public aid in either construction or maintenance. Such hospitals in this country have always been built by private contributions - large and small. Large gifts from wealthy contributors have played an important part. It has not been uncommon to see hospitals built as monuments to wealthy persons, often where not needed. Thus our present hospital pattern has developed with little systematic thought. Even these sources of construction funds have diminished in recent years. With changes in the economic structure of the country, large private contributions may become fewer and fewer. Rising costs of construction and equipment have now placed hospital costs beyond the reach of many communities.

In brief summary, S. 191 proposes a program of Federal grants-in-aid for two purposes:

1. To assist the States to ascertain their hospital and public health-facility needs through State-wide surveys and to develop State-wide programs for construction of those facilities needed to supplement existing facilities so as to serve all the people of the State, and
2. To aid in the construction of those necessary facilities for public and voluntary nonprofit hospitals and for public health centers, which State and local resources can help build and can maintain, and which are in conformity with the approved State construction program and the standards for construction projects required under the bill.

An appropriation of \$5,000,000 is authorized for the survey and planning features of the bill, and \$75,000,000 for each of the five fiscal years 1947 to 1951 for the construction program.

The Federal administration of this program would be entrusted to the Surgeon General of the United States Public Health Service, Federal Security Agency, who would have the assistance of a Federal Hospital Council. This Council, consisting of the Surgeon General and eight members appointed by the Federal Security Administrator, representing both producers and consumers of hospital and health services, would share responsibility with the Surgeon General in the framing of general regulations establishing standards for State construction plans. The Council would also constitute the appeals body, in the event a State agency requested a hearing following the Surgeon General's disapproval of a State construction plan. The Council's other functions would be advisory.

It would be required that the State construction plan be administered by a single State agency, in consultation with a State advisory council composed of representatives of nongovernment, as well as

^{10/} Report of the Senate Committee on Education and Labor, Report No. 574, 79th Congress, 1st Session, October 30, 1945.

government, groups concerned with the operation, construction, utilization, and need of hospitals and public health facilities. During the period of survey, there would be the same requirements of a single State agency and of consultation with a State advisory council.

Allotments to the States are on a statutory formula providing that the Federal percentage shall be such that the remaining non-Federal percentage bears the same ratio to 50 per cent as the per capita income of the State bears to the national per capita income; the bill fixes a maximum limit of 75 per cent and a minimum limit of 33.33 per cent on the Federal percentages. Also, the Federal funds allotted to each State must bear the same ratio to the total appropriation authorized as the product of its population and the square of its Federal percentage bears to the sum of the corresponding products for all States. It is estimated that for New York State, this would mean a 33.33 per cent Federal appropriation amounting to \$2,873,000, which would have to be matched by State, local or private funds in the amount of \$5,746,000. If the hospitals of the State do not take advantage of all or a part of the Federal appropriation, the sum allotted will be held over for the succeeding year, but if it is not then taken up, it will revert to the general fund to be redistributed among all of the States. It therefore behooves a State to be prompt in making the necessary surveys and administrative arrangements to permit these Federal funds to become available to private and State and local public hospitals.

In no instance is the State required to contribute any State moneys to private or local public hospitals, although it must carry its share of the operating costs of the State surveying and administrative agency. The bill guarantees local autonomy by specifically prohibiting Federal control or supervision over any hospital receiving funds under the measure. The State agency has the responsibility of deciding which of the applications made by hospitals are most worthy and needed to correct local deficiencies in hospital service.

The Commission on Medical Care being vitally interested in the extension and improvement of hospital facilities, the Chairman called a meeting on April 3, 1945, of representatives of this Commission, the Health Preparedness Commission, and the State Departments of Health, Mental Hygiene, and Social Welfare to make plans jointly so that New York State might benefit by the financial aid offered by the Hill-Burton bill. At the meeting it was agreed that a special State agency should be formed, preferably by executive action, to deal with this matter. On June 22, 1945, the Commis-

sion directed a resolution to the Governor asking him to take steps to insure that New York State could immediately qualify for benefits if S.191 were enacted. The Governor subsequently designated the New York State Postwar Public Works Planning Commission to act under the guidance of a Joint Hospital Board composed of the Commissioners of Health, Mental Hygiene and Social Welfare, with the Chairman of the Health Preparedness Commission in an advisory capacity.

The limitation of Federal participation to one-third may continue to make it difficult for some poor localities to raise the remaining two-thirds of the funds necessary. As the needs of the localities are periodically surveyed it may become apparent that the State Constitution should be amended (as in the case of public housing) to permit State loans or grants to public corporations for hospital construction.

Licensure and Supervision

The quality of care is an integral part of any medical care program. The quality of care provided by hospitals in New York State has undoubtedly been enhanced through the efforts of non-official bodies such as the American Medical Association, American Hospital Association and the American College of Surgeons. Equally or more important are the activities of the hospital boards and staffs themselves. These are all voluntary, non-official undertakings, however, and do not affect a number of hospitals which may be heedless of and in need of improvement in quality.

To guarantee good standards in all hospitals, some element of compulsion seems necessary. In a degree, supervision is exercised by the State Department of Social Welfare under the authority of Article XVII of the State Constitution. However, the authority of the State Department of Social Welfare is deficient in scope, owing to the fact that hospitals must be in receipt of public funds to come under its jurisdiction. Certain general and special hospitals and numerous convalescent and nursing homes are subject to little, if any, regulation. Further, the organization of the State Department of Social Welfare does not at present provide for medical supervision of these medical institutions, nor is provision made for representation of such interests as physicians, nurses and hospital directors on a policy-making, quasi-legislative or advisory board dealing with hospital regulation.

Hospital and dispensary licensure law. The American Hospital Association has suggested that States adopt a system of licensing and supervision of hospitals, and it would seem desirable to include clinics and

dispensaries as well. A model law based upon one prepared by the American Hospital Association and modified as has seemed necessary by present New York State laws and legislative and administrative patterns, follows. The proposed act omits definition of the necessary policy-making or advisory body since the exact composition and function of such body would depend upon the nature of the agency responsible for administering the act.

AN ACT regulating hospitals, infirmaries, sanatoria, maternity homes, nursing homes, convalescent homes, dispensaries, clinics, out-patient departments, and related institutions, and amending certain provisions of the social welfare law, the membership corporations law and the penal law.

1. Short title. This chapter shall be known as the hospital and dispensary law.
2. Definitions. When used in this chapter unless otherwise expressly stated or unless the context or subject matter requires a different interpretation

1. Hospital means any hospital, infirmary, sanatorium, maternity home, convalescent home and other related institution conducted in or by an institution, place, building or agency, whether incorporated or unincorporated, except the state departments of health, mental hygiene, correction, social welfare and education, or an institution subject to the jurisdiction of the state department of mental hygiene, into which any person not related to the proprietor or person in charge by blood or marriage is received for maintenance and care of any illness, injury or condition relating to pregnancy, provided, however, that this definition shall not apply to hotels, lodging houses or other similar places that furnish only board or room, or either, to their guests.
2. Clinic means any clinic, dispensary, hospital out-patient department or other related institution conducted by any institution, association, partnership or agency, whether incorporated or unincorporated, except the state departments of health, mental hygiene, correction, social welfare and education, whose purpose it is to furnish to persons non-resident therein medical, surgical or dental advice or treatment, provided, however, that this definition shall not apply to any individual engaged in the practice of medicine or dentistry as defined by law.
3. Department means the

4. Commissioner means the commissioner of the state
5. Hospital director means the proprietor or chief executive officer of any hospital as defined above.
6. Clinic director means the chief executive officer of any clinic as defined above.
7. Municipality means any town, incorporated village, special or consolidated health district, city or county of this state.
3. License required. No hospital or clinic shall enter upon the execution, or continue the prosecution of its purpose unless licensed by the department as provided herein.
4. Application for license.
 1. An application in writing for a license shall be made annually by the hospital director or clinic director to the department in the form and manner prescribed by it. There shall be attached to the application a statement, verified by oath of the applicant, containing such facts as the department may require.
 2. The commissioner of or his authorized representative may take investigations and inquiries, and hold hearings for the purpose of obtaining such additional information as may in the judgment of the be necessary for consideration of the application.
5. License fee. An application for a license shall be accompanied by a fee of the amount set forth below, provided, however, that no fee shall be required of a hospital or clinic owned and operated by a municipality.
 1. For a hospital of less than 50 beds, \$25.00; more than 50 but less than 100 beds, \$35.00; more than 100 but less than 200 beds, \$50.00; more than 200 beds, \$75.00
 2. For a clinic, \$25.00
 3. Fees shall be payable to the department All sums realized therefrom shall be deposited with the state treasurer in the general fund of the state.
6. Issuance of license.
 1. If in the judgment of the the application filed, and other evidence submitted or obtained in relation to such application, indicate that the operations of a hospital or clinic will be for the public benefit, a license shall be issued to the hospital or clinic applying therefor.
 2. No license shall be transferable or assignable.

7. Expiration of license. Licenses shall be issued for a period of not more than one year and shall expire December 31 of each year.

8. Rules and regulations.

1. The department shall establish and may alter and amend rules concerning records, buildings and equipment, personnel and standards of care which it finds to be necessary and in the public interest.
2. Such rules shall state the date upon which they take effect and shall have the force and effect of law if
 - a. filed as a public record in the offices of the department
 - b. filed in the office of the department of state, and
 - c. sent to the hospitals and clinics affected thereby, and
 - d. published in such manner as the department shall determine or as otherwise provided by law.
3. Any hospital or clinic aggrieved by such rules shall have the right, upon establishing interest, to appeal to a court of competent jurisdiction for review as to the reasonableness thereof.

9. Visitation, inspection and supervision.

1. The commissioner shall from time to time visit and inspect, and maintain general supervision of licensed hospitals and clinics. He may examine all matters in relation to said hospitals and clinics and ascertain how far they are conducted in compliance with the rules of the department.
2. Any member, officer or duly authorized employee of the department shall have full access to the grounds, buildings, books and papers relating to said hospitals and clinics, and may require from the officers and persons in charge thereof any information he may deem necessary in the discharge of his duties.
3. No such officer or employee shall divulge or communicate to any person without the knowledge and consent of the department or of the commissioner any facts or information obtained pursuant to the provision of this act.
4. Any officer or employee of said hospital or clinic who shall refuse to admit any member or officer or inspector of the department, for the purpose of inspection, or shall refuse or neglect to furnish the information required by the department or any officer or inspector shall be guilty of a misdemeanor.
5. Inspection reports shall be prepared on forms prescribed by the commissioner. One copy of the report shall be sent to the direc-

tor and one copy to the trustee, directors, or managers of the hospital or clinic which is the subject of the report. Inspection reports shall set forth clearly any recommendations deemed necessary to secure full compliance with the rules of the department and the intent of this act.

10. Construction. Prior to the construction or erection of any hospital or clinic, plans and specifications therefor shall be submitted in duplicate to the department. Within a period of 60 days after receipt of such plans and specifications one set shall be returned to officers or managers or proprietor of said hospital or clinic, together with the recommendations, if any, of the department for such changes, alterations or additions as shall seem to the department to be wise and necessary, provided, however, that such recommendations shall be advisory only and shall not be binding upon the officers, managers or proprietor of said hospital or clinic.

11. Orders of department. If it shall appear, after visitation and inspection that any hospital or clinic is being conducted in a manner prejudicial to the public health, safety and interest, the department may issue an order in the name of the people, directed to the proper officials or management of a licensed hospital or clinic, requiring remedy of the condition therein specified. Before such an order is issued, it must be approved by a justice of the supreme court, after such notice as he may prescribe and an opportunity to be heard.

12. Revocation of licenses.

1. After due notice to a hospital or clinic, and opportunity for it to be heard, the department may, if the public interest demands, and for just and reasonable cause, revoke a license by an order signed and attested by the commissioner. Such order shall state the reason for revoking such license and shall take effect within such time after the service thereof upon the hospital or clinic as the department shall determine.

2. If a license is revoked as provided herein, a new application for a license shall be considered by the department upon the submission of evidence which shall satisfy the department that issuance of a license will be in the public interest.

13. Powers and duties of the commissioner. All of the administrative and executive powers and duties of the department conferred by this act shall be vested in the commissioner, who shall have the power to

delegate one or more deputies to act in his stead.

14. Constitutionality. If any provisions of this act shall be held to be unconstitutional, such decision shall not effect the validity of the remainder of this act.

15. Interpretation. Nothing herein shall be construed to diminish or impair the constitutional right of the State Department of Social Welfare to visit or inspect any charitable institution in receipt of public funds.

Clinics and Dispensaries

In addition to the clinics and dispensaries operated by State and local health and education departments and the State Department of Mental Hygiene, which do not come under the supervision of the State Department of Social Welfare^{11/}, there were 229 dispensaries under the supervision of the State Department of Social Welfare in 1943, to which 1.2 million persons made 6.5 million visits. A marked decline in the volume of service has occurred with the upturn in economic conditions, 1.9 million persons having made 10.2 million visits in 1939. A majority of these dispensaries are operated by hospitals.^{12/} 1943 data on the location of dispensaries by county and district, and clinic visits in that year are shown in Table 17. Dispensaries are situated almost entirely in the larger cities and the number of visits per 1,000 population is thus extremely variable among counties and districts. A majority of counties have no dispensaries.

Cost data. The figures available on costs are not very enlightening. From the study of EMIC hospital data, the average cost per visit was determined for the "voluntary" hospitals and is shown in Table 18, but from the individual reports it appeared that a majority of hospitals did not keep exact records of out-patient costs. The common practice was to assign a value of \$1.50 per visit and to calculate the total out-patient cost by multiplying the number of visits by this figure. Where records appear to have been kept, the costs are extremely variable, probably because in many instances the only out-patient services provided were x-ray examinations and similar expensive procedures. Also, the cost depends greatly upon whether any payment is made to physicians for services in the

^{11/} Social Welfare Law, Article 9. Applies only to dispensaries furnishing services or supplies "...gratuitously or for a compensation determined without reference to the value of the thing furnished..."

^{12/} For detailed data on dispensaries, see Directory of Hospitals and Dispensaries, State Department of Social Welfare, Albany, and annual reports of the State Department of Social Welfare.

clinic. It is believed that such payment is rarely made in the hospitals covered by this study. The variations in clinic costs reported are shown in Table 19.

Table 17. Location of Dispensaries and Service Rendered, New York State, 1943 ^{13/}

County	No. of clinics	Clinic visits	
		Number	Per 1000 population
Albany District			
Albany ^{a/}	6	42,030	185
Renssalaer	5	8,769	73
Saratoga	1	1,164	17
Schenectady	2	1,985	15
Washington	1	5,914	137
Total	15	59,862	60
Buffalo District			
Chautauqua	1	196	2
Erie ^{a/}	22	173,751	203
Niagara	1	1,678	9
Total	24	175,525	152
Rochester District			
Monroe ^{a/}	9	200,443	445
Total	9	200,443	213
Syracuse District			
Broome	1	1,020	6
Cayuga	2	2,546	42
Jefferson	1	3,397	41
Oneida	1	12,907	61
Onondaga ^{a/}	3	48,935	158
Total	8	68,905	52
New York District			
Dutchess	4	8,730	82
Nassau	2	5,104	11
Orange	3	5,174	39
Rockland	1	671	11
Suffolk	2	6,167	32
Ulster	1	93	1
Westchester	14	116,316	207
New York City ^{a/146}	5	820,186	753
Total	173	5,962,441	654
Entire State			
Total	229	6,467,276	467

^{a/} Medical school in county.

Table 18. Number and Cost of Out-patient Visits, "Voluntary" Hospitals, ^{a/} New York State, 1945

District	Thousands of visits	Cost per visit
Albany	101	\$1.86
Buffalo	85	1.15
Rochester	200	1.41
Syracuse	124	1.39
New York City	2,867	1.95
Remainder	271	1.58
Entire State	3,649	1.87

^{a/} See footnote, Table 7.

Table 19. Distribution of "Voluntary" Hospitals ^{a/} by Cost of Out-Patient Clinic Visits, New York State, 1945.

Cost per visit	New York City	Rest of State
Under \$0.75	0	3
.75-.99	3	1
1.00-1.24	1	1
1.25-1.49	4	4
1.50-1.74	21	101
1.75-1.99	4	1
2.00-2.24	3	3
2.25-2.49	7	1
2.50-2.74	4	0
2.75-2.99	2	0
3.00 or more	7	5

^{a/} See footnote, Table 7.

^{13/} Adapted from Public Social Services in 1944, State Department of Social Welfare, Albany.

CHAPTER XV

STATE AND NATIONAL MEDICAL INSURANCE

State and national systems of health insurance had their inception in 1851, and their development has continued as a strong, steady social trend. At first the emphasis was upon the payment of cash benefits during periods of illness. This has continued to be a feature of the great majority of plans, but the provision of medical services has become more and more important. Also, in the beginning, the plans were chiefly for low-income workers, but they have steadily expanded in scope to offer first, coverage of dependents of such workers, and second, coverage on the basis of citizenship rather than employment status, in some of the more recently adopted or revised plans.

Information concerning a majority of the plans in operation today has been taken from the Canadian report on health insurance.^{1/} The authors point out that some of the information is incomplete or obsolete because of abnormal world conditions since 1939. There are 9 countries which are

classified as having national voluntary health insurance plans, as shown in

Table 1. However, only the Belgian and Swedish plans receive definite governmental subsidies which would serve to distinguish them from the voluntary medical care, hospitalization and mutual benefit organizations in this country. In Belgium, the subsidy is to the voluntary societies,

Table 1. Date of Establishment and Certain Characteristics of National Voluntary Health Insurance Plans^{1/}

Country	Date established	Medical service benefits	Government subsidy
Belgium	1851	Yes	Yes
Spain	1887	Yes	<u>b/</u>
Austria	1888	<u>a/</u>	<u>a/</u>
Sweden	1891	Yes	Yes
Union of South Africa	1892	Yes	No
Finland	1897	Yes	No
Iceland	1911	Yes	<u>b/</u>
Uruguay	<u>a/</u>	<u>a/</u>	<u>a/</u>
Bolivia	<u>a/</u>	Yes	<u>a/</u>

a/ Unknown.

b/ Limited to localities or certain circumstances.

based on the membership and the amount of contributions received, and is usually about equal to that paid by the insured persons. In Sweden, there is an annual fixed subsidy based on membership, and a subsidy of about 50 per cent of the amount of benefits paid out.

The Province of Saskatchewan has an intermediate arrangement, a "municipal doctor system", wherein a number of the rural localities make an annual grant or guarantee a certain income to a physician, in turn for

^{1/} Health Insurance, Report of the Special Committee on Social Security, House of Commons, Ottawa, 1943.

which the indigent are entitled to medical care and all residents are entitled to certain preventive services.

Through 1942, some 33 countries had placed national compulsory health insurance plans in operation, as shown in Table 2. In addition, the Province of Alberta adopted a compulsory plan in 1935 which was not put into effect because of its relationship to a "Social Credit" plan which would

Table 2. Date of Establishment of National and State Compulsory Health Insurance Plans in Operation, 1942^{1/}

Country	Date	Country	Date	Country	Date
Germany	1883	Esthonia	1917	Netherlands	1925
Austria	1888	Bulgaria	1918	France	1930
Hungary	1891	Czechoslovakia	1919	Brazil	1931
Luxembourg	1901	Portugal	1919	Denmark	1933
Norway	1909	Poland	1920	Peru	1936
Great Britain		Greece	1922	New Zealand	1938
& No. Ireland	1911	Japan	1922	Ecuador	--
Eire	1911	Latvia	1922	Venezuela	1940
Switzerland	1911	Yugoslavia	1922	Costa Rica	1941
Russia	1911	Chile	1924	Panama	1941
U.S.S.R.	1922	Italy	1925	Mexico	1942
Rumania	1912	Lithuania	1925	Rhode Island	1944

provide an annual cash payment of \$300 to every resident. In 1936 the British Columbia legislature passed a compulsory health insurance act which has not gone into effect

....because cooperation of the medical profession could not be secured. This opposition was owing chiefly to the decision of the Government not to include indigents in the scheme. It was also felt that the financial burden of putting the act into effect would be too great for the province to bear alone, and its adoption was held in abeyance in the hope that the Dominion might come to the assistance of the province by means of a subvention.^{1/}

In 1938 the Australian parliament passed a compulsory health insurance act which has not been put into operation owing, it is believed, to failure to secure the cooperation of the medical profession. The Province of Ontario adopted a compulsory health insurance act in 1945, which has not yet been put into operation, probably because of the difficulties encountered by municipalities in developing revenues in the absence of an anticipated Dominion subsidy. The Dominion of Canada, Argentina, Colombia and Paraguay are said to be seriously considering adoption of compulsory health insurance.

In the United States, Rhode Island is the only State to have adopted compulsory health insurance, although the Rhode Island plan is limited to cash sickness benefits for employed workers. However, for the country as

Table 3. Population Coverage Afforded by National Compulsory Health Insurance Plans^{1/}.

COUNTRY	OCCUPATIONS COVERED			INCOME LIMIT FOR		DEPENDENTS COVERED		Ages Covered	Percentage of Population Covered
	Wage Earners (Manual Workers)	Salaried Employees	Others	Manual Workers	Others	Wife	Children		
AUSTRIA.....	Commerce Industry Mining Agriculture Personal Services	Commerce Industry Mining Agriculture Personal Services				X	X		66%
BULGARIA.....	All	All				No	No		31%
CHILE.....	All	All	X	12,000 pesos	12,000 pesos	No ¹	No ¹	All under 65	30%
CZECHOSLOVAKIA.....	All	All	X			X	X		47%
DENMARK.....	All ²	All ²	All ²	4,200 kroner ³	4,200 kroner ³	No ⁴	X	21 to 60	80%
EIRE.....	All	All		None	£250	No	No	All over 16	16%
ESTHONIA.....	Industry Mining Navigation Buildings	Industry Mining Navigation Buildings	Small masters			Optional	Optional		
FRANCE.....	Industry Commerce Agriculture	Industry Commerce Agriculture	Home-workers	15,000 to 25,000 francs	15,000 to 25,000 francs	X	X	13 to 60	50%
GERMANY.....	All	All	X	None	3600 R.M.	Optional	Optional		66%
GREAT BRITAIN.....	All	All		None	£420	No	No	14 to 65	40%
GREECE.....	All	All							
HUNGARY.....	All except agricultural workers	All		None	3600 pengo	X	X		
ITALY.....	Industry Commerce Transport Agriculture Seamen and Airmen	Industry Commerce Transport Agriculture Seamen and Airmen			9600 lire	In some schemes only	In some schemes only		22%
JAPAN.....	Industry Mining			1200 yen		No	No		3%
LATVIA.....	All	All	X			Optional	Optional		
LITHUANIA.....	All but agricultural workers	All	None	4800 litas	4800 litas	X	X		
LUXEMBURG.....	All	All	None	None	10,000 francs	No	No		
NETHERLANDS.....	All	None	None	3000 florins		No	No		
NEW ZEALAND.....	All	All	All	£208 ⁴	£208 ⁴	X	X	All over 16	100% ^{b/}
NORWAY.....	All	All			4500 kroner	No	No	All over 15	20%
PERU.....									
POLAND.....	All except agricultural workers	All	Home-workers	8700 zloty	8700 zloty	X	X		7%
PORTUGAL.....	Trade union members	Trade union members							
RUMANIA.....	All except agricultural workers	X	X	72,000 lei	72,000 lei	X	X		
SWITZERLAND ⁵									
U.S.S.R.....	All	All	All	None	None	X	X		100% ^{b/}
YUGOSLAVIA.....	All except agricultural workers	All	None			X	X		

¹ Consideration now being given to extending scope to dependents.² Either actively or passively insured.³ Limit for active insurance.⁴ Expected to be insured in her own right.⁵ Limit for receipt of cash benefits only.⁶ Considerable variation in schemes.^{a/} Ages covered refers only to requirement of payment of registration fee.^{b/} Figures added from supplementary data.

Table 4. Administrative Agency, Choice of Physician, and Method of Paying Practitioner under National Compulsory Health Insurance Plans.

COUNTRY	ADMINISTERED		Free Choice of Doctor	METHOD OF PAYING PRACTITIONERS		
	Directly by the State	Through Approved Societies		Salary	Fee Basis	Per Capita Basis
AUSTRIA.....		X	Varies	X	<u>X</u>	
BULGARIA.....	X					
CHILE.....	X		No	X		
CZECHOSLOVAKIA.....		X	No			X
DENMARK.....		X	Yes		X	<u>X</u>
EIRE.....	X					
ESTHONIA.....		X				
FRANCE.....		X	Yes		X	
GERMANY.....		X	Yes	X	<u>X</u>	X
GREAT BRITAIN.....		X	Yes			X
GREECE.....						
HUNGARY.....	X		No			
ITALY.....		X				
JAPAN.....		X				
LATVIA.....		X				
LITHUANIA.....	X		No	X		
LUXEMBURG.....		X				
NETHERLANDS.....		X				
NEW ZEALAND.....	X		Yes	x	X	x
NORWAY.....		X	Yes		X	
PERU.....	X		No	X		
POLAND.....	X		No	X		
PORTUGAL.....		X				
RUMANIA.....		X				
SWITZERLAND.....		X			X	
U.S.S.R.....	X		No	X		
YUGOSLAVIA.....	X		No	X		

Underlined X means more usual procedure.

Table 5. Benefits Provided under National Compulsory Health Insurance Plans^{1/}.

COUNTRY	TYPES OF BENEFITS										Qualifying Period	Time Limit	Provided for Dependents as well as Insured
	General Practitioner Treatment	Surgical Treatment	Specialist Treatment	Maternity Care		Hospital	Medical Appliances	Pharmaceutical	Dental	Special Preventive Benefits			
				Insured only	Insured and Dependents								
AUSTRIA.....	X					X					30 weeks	52 weeks	Optional
BULGARIA.....	X		X	X		X		X			8 weeks	38 weeks	
CHILE.....	X		X		X	X		X	X	X	None	52 weeks	Optional
CZECHOSLOVAKIA.....	X				X		X	X			None	None	X
DENMARK.....	X	X				X	X	X	X		6 weeks	26 weeks	X
EIRE ¹													
ESTHONIA.....	X			X		X	X	X			None	26 weeks	Optional
FRANCE.....	X ²		X ²			X ²		X ²				26 weeks	X
GERMANY.....	X	X			X	X	X	X	X			26 weeks or more	X
GREAT BRITAIN.....	X	None	None			None		X			None	None	No
GREECE.....	X												
HUNGARY.....	X			X		X	X	X			None	52 weeks	X
ITALY ³	X		X	X				X			None		
JAPAN.....	X					X	X	X	X			26 weeks	No
LATVIA.....	X			X		X		X				26 weeks	Optional
LITHUANIA.....	X					X		X				26 weeks	For 13 weeks
LUXEMBURG.....	X				X	X	X	X	X	X	None	26 weeks	
NETHERLANDS ⁴				X									
NEW ZEALAND.....	X			X ⁵		X		X				None	
NORWAY.....	X				X	X			X			26 weeks	X
PERU.....	X	X				X		X					
POLAND.....	X				X	X	X	X			None	39 weeks	
PORTUGAL ⁶													
RUMANIA.....	X		X	X			X	X			None	None	X
SWITZERLAND ⁷													
U.S.S.R.....	X	X	X		X	X	X	X	X	X	None	None	X
YUGOSLAVIA.....	X				X	X	X	X				26 weeks	X

¹ None until 1942 Amendment whose provisions are not yet definite.² 80% reimbursement.³ These are benefits in kind for industrial workers.⁴ Provision only for cash benefits but insured must belong to a voluntary sickness fund granting benefits in kind.⁵ Everyone is insured.⁶ Benefits vary according to the fund insured with.⁷ Large number of schemes with varying benefits.

Table 6. Sources of Revenues under National Compulsory Health Insurance Plans^{1/}.

COUNTRY	CONTRIBUTORS			CONTRIBUTIONS				Insured Divided into Wage Classes
	Insured	Employer	State	Type		Amount		
				Flat Rate	Percentage of Wages	Total	Insured	
AUSTRIA.....	50%	50%	No					No
BULGARIA.....	33-1/3%	33-1/3%	33-1/3%		X			Yes
CHILE.....	24%	59%	17%		X	8-1/2% of weekly wage	2% of weekly wage ¹	
CZECHOSLOVAKIA.....	50%	50%	No		X			Yes
DENMARK.....	X	No	S ^{2,3}				Average weekly contribution is 0.41 krone	
EIRE.....	39%	39%	22% ⁴	X			4d weekly	No
ESTHONIA.....	50%	50%	No		X		1% to 2% of wages	Varies
FRANCE.....	50%	50%	S		X	8% of wages	4% of wages	
GERMANY.....	50%	50%	No		X	Cannot exceed 6% of wages		
GREAT BRITAIN.....	43%	43%	14%	X			5-1/2d ⁵	No
GREECE.....	X	X	No				1.6% of mid-point of wage class	Yes
HUNGARY.....	50%	50%	S			Cannot exceed 6% of wages		Yes
ITALY.....	50%	50%			X	3% of daily wage ⁶		
JAPAN.....	45%	45%	10%		X		Cannot exceed 3% of wages	No
LATVIA.....	37-1/2%	37-1/2%	25%		X		Cannot exceed 2% of wages	
LITHUANIA.....	33-1/3%	33-1/3%	33-1/3%		X		Cannot exceed 3% of mid-point of wage class.	Yes
LUXEMBURG.....	66-2/3%	33-1/3%	S		X	Cannot exceed 4.5% of normal wage		
NETHERLANDS.....	50%	50%	No		X			
NEW ZEALAND.....	X		X		X		£1 a year plus 5% of income	No
NORWAY.....	60%	10%	20% ⁷		X			
PERU.....	X	X	S ⁸		X			
POLAND.....	40%	60%			X	6.5% of basic wage		Yes
PORTUGAL.....	X	X						
RUMANIA.....	X	X	S		X	Cannot exceed 6% of midpoint of wage class		Yes
SWITZERLAND.....	X		S ⁹					
U.S.S.R.....	No		100%					No
YUGOSLAVIA.....	50%	50%	No		X			Yes

¹ Covers all branches of social security.² Plus cost of central administration.³ Commune pays 10% of cost.³ S — Sudaity.⁴ Figures are for men.⁵ Equal to half the contributions.⁵ Communes pay a large share of the costs.⁶ For land and river transport workers.⁷ Also cantonal subsidies, communal subsidies and employers' subsidies.

a whole, and in a number of individual States - California, Rhode Island, Arkansas, Connecticut, West Virginia, Michigan, New Mexico and Wisconsin - plans for compulsory medical insurance are being studied or have been seriously proposed.

Summary of Features of Existing National Plans

The varying coverage, benefits, administrative and revenue provisions of a number of the national systems are summarized in Tables 3, 4, 5 and 6. In addition, certain plans have been studied in detail by the Commission staff.

Great Britain

Prior to 1911, Great Britain had a widespread system of voluntary health insurance through trade and fraternal societies offering to the working classes various types of insurance, including cash sickness and medical benefits. Competition between these societies led to a reduction of physicians' fees to permit lowered insurance rates. This resulted in substandard medical service and inadequately reimbursed physicians. To relieve this situation, and to safeguard the health of the workers, in 1911 a compulsory health insurance system was established with the cooperation of the British Medical Association. The original system is still in effect.

Coverage. The British system provides limited medical service and cash sickness benefits to all manual workers and to low-income non-manual workers. The dependents of workers are not covered. The system covered 18.1 million persons in 1936.^{2/} A February 1944 estimate placed coverage in England and Wales at 21.0 million.^{3/} It is estimated that coverage in Scotland increased to 2.2 million by that date,^{4/} giving a total for Great Britain of 23.2 million for 1944.

Before the wartime employment expansion, approximately 40 per cent of the total population and 80 per cent of the working population was covered. In recent years, however, the proportion of persons covered has increased to 50 per cent.

Benefits and their provision. Statutory medical benefits include services of a general medical practitioner in office or home, and certain

^{2/} Social Insurance and Allied Services ("The Beveridge Report"), Sir William Beveridge, Macmillan Company, New York, 1942.

^{3/} A National Health Service ("The White Paper"), British Ministry of Health and Department of Health for Scotland, Macmillan Company, New York, 1944.

^{4/} By applying to Scotland the same percentage increase as occurred in England and Wales.

prescribed drugs and appliances. Specialist, maternity, and hospital services are excluded.

Medical service is provided through a local Insurance Committee consisting of elected representatives of insured persons and representatives of the local physicians, the local County Council, and the Minister of Health. The panel system of registration of physicians is used. Every licensed practitioner may elect to have his name entered on the panel of persons eligible to give service. The government does not influence patient or physician as to choice. A physician working alone may not accept more than 2500 insurance patients, and one working with a full-time assistant, not more than 4000 insurance patients. The right of panel physicians to treat non-insurance patients is in no way affected.

A sum is allocated to each local Insurance Committee by the central authorities to cover the cost of medical services, the amount being based on the number of insured persons in the area. The local insurance physicians may choose whether this sum is to be divided by capitation (i.e., according to number of insured persons choosing the physician, whether or not service is rendered to such persons), by amount of service rendered, or by a combination or modification of these methods. Physicians in all areas have chosen payment by capitation. No direct financial relation between patient and physician exists for the services covered by insurance.

A pharmaceutical panel similar to the physicians panel is set up for pharmacists wishing to provide medicines to insured persons. The rate of payment for medicines and appliances is fixed by schedule.

Costs and payments. It is extremely difficult to express the costs of the British system in United States dollars. In his analysis of British medical insurance in 1934-35, Falk^{5/} valued the pound at \$4.866. On such basis the annual capitation fee of 9 shillings would amount to about \$2.18 per year for general practitioner services, exclusive of mileage, remuneration for medicines used in practice, etc. If, however, the pound is valued in terms of relative wage and salary income, a different figure is obtained. The normal pre-war average weekly wage of the male worker in Great Britain was about 60 shillings,^{6/} whereas in the United States it was \$27.02 in the same period.^{7/} In terms of 1940 purchasing power, the shilling seems to have had a relative value of about \$0.45, and the

^{5/} Security Against Sickness, I.S. Falk, Doubleday Doran, Garden City, 1936.

^{6/} National Health Insurance, Hermann Levy, The University Press, Cambridge, 1944.

^{7/} Industrial Bulletin, New York State Department of Labor, 24:225, June 1945.

pound, \$9.00. Assuming this value for purposes of comparison, the capitation fee would be about \$4.05.

For this sum the panel physician provides, on the average, 2.3 office calls and 1.2 home calls,^{6/} and realizes an income of about \$1.15 per call. For the same amount of service, a United States physician would expect at least \$8.20 on the basis of \$3.00 per home call and \$2.00 per office call. It seems likely, as claimed, that the British panel physician's service tends to be cursory because of the low rate of payment. It is estimated on the basis of a 30 hour work-week (i.e., 30 hours devoted to actually seeing patients), 48 weeks per year, that to be assured of a gross income of \$10,000, a physician would need 2,000 patients on his panel and to make 7,000 calls. These calls would average only 12 minutes as compared with an estimated 17 minutes in the United States. Estimated differently, on the basis of a maximum capacity of 125 calls weekly,^{8/} a physician could earn about \$6,800 gross, exclusive of mileage; or, on the basis of 106 calls weekly,^{8/} about \$5,800. These earnings, it must be remembered, are based on a pound valued at about \$9.00 rather than the exchange rate, which is about one-half of such amount. It appears that the chief factor in making panel practice tolerable at relatively low rates is that it ordinarily constitutes only a part of the physician's practice, providing an assured income of small amount and permitting him to realize additional income at larger fees from uninsured patients or for services not covered by insurance. For example, 35 per cent of physicians had panels of less than 600 persons, 30 per cent had 600-1,200, 21 per cent had 1,200-2,000, and only 14 per cent had 2,000 or more.^{6/}

The view has been expressed that British physicians should be willing to accept a low capitation fee for services rendered to the persons eligible for insurance since they constitute a class which can not afford the individual purchase of adequate medical care, and which otherwise would become charity patients or would not pay in full for services received. According to this view, the arrangement is advantageous to both parties. However, employing the most generous interpretation of the rate of remuneration, the payments seem to be out of keeping with a quality of service which would be satisfactory from the standpoint of the physician or the insured. Although the capitation rate of 9 shillings may have been satisfactory in 1923, it has not changed up to the present (except for a 10 per cent reduction during 1931-34, and a 5 per cent reduction during 1934-35).

^{8/} See Chapter XIII.

The system thus does not seem to be well adjusted to fluctuations in earnings and the cost of living. A physician would earn no more from insurance practice during an inflationary period than he would earn in normal times. It would seem, as remarked below, that the flat-rate system of contributions has played an important part in the inflexibility and resultant shortcomings of the plan, which has shown little progress since its inception.

Administration and financing. The existence of influential voluntary insurance societies with a vested interest in their continued activity in the field of health insurance resulted in the incorporation of such societies into the compulsory health insurance plan. All insured persons must belong either to an Approved Society (a voluntary non-profit insurance society), or to the government-sponsored Deposit Contributors Fund. Compulsory health contributions by employer (43 per cent), employee (43 per cent) and the government (14 per cent), are paid into a national fund through a stamp system. After deductions for the cost of medical benefits, appropriate credits are assigned to each Approved Society according to the contributions received from its members.

The government provides the statutory medical service benefits. The local Insurance Committees and the Approved Societies provide the cash sickness benefits. Any surplus funds in the hands of the Approved Societies after payment of the minimum cash sickness benefits may be used by them to finance additional cash or service benefits. Additional medical benefits provided by the Approved Societies from surplus funds or additional contributions are most frequently for dental and eye care. A member of a Society which furnishes dental care may obtain from his Society a letter stating his eligibility for such benefits. The dentist accepting this patient is paid jointly by the Society and the patient on the basis of a fixed schedule of fees. Eye care benefits are administered by the Societies in a similar manner.

Contributions by the insured are at a flat rate, with an equal amount paid by the employer, and a subsidy from the Government. This system of contribution, which seems to be inextricably associated with limited benefits, inadequate payments to physicians, and administration through a multiplicity of Approved Societies, seems to lie at the bottom of the causes for the dissatisfaction with and the inadequacies of the British system. The experience in Great Britain does not discredit the value or advantages of compulsory medical insurance, but it does illustrate clearly how the best of intentions may not suffice if the financial and administrative features of an insurance plan are not basically sound and flexible.

Appraisal. Aside from the compulsory health insurance system and the poor laws, there is no provision for general medical attention on any considerable scale. Medical and hospital care may be furnished on a limited basis to the indigent and the medically indigent by local authorities, but there is no coordination of these activities with the medical insurance system.

There have been many criticisms of the existing compulsory health insurance system by both the organized medical profession and the public. These critics, however, emphasize the need for reorganization of the system, and do not propose that it should be abandoned.

The organized medical profession, which was at first bitter about many provisions in National Health Insurance, has come to its support. In 1926, the profession expressed the opinion that "the evidence as to the incidence of sickness benefit does point to the fact that the scheme has almost certainly reduced national sickness," and that it endorsed continuance of medical benefits since more persons were receiving care, the quality of care given was superior to that under the previous system of voluntary insurance through Friendly Societies, illness was treated earlier, emphasis was placed on prevention, etc.^{9/}

In 1930, the British Medical Association proposed as an answer to many existing defects in medical practice: "First, enlarging the scope of medical benefit to include specialist treatment, dental service, institutional care, etc.; second, enlarging the scope of the insured population to embrace the dependents of insured persons; and third, consolidating the administration of insurance medicine with other medical bodies (public health, poor law, hospital services, etc.)"^{10/}

Sir Henry B. Brackenbury, Chairman of the Council of the British Medical Association, in an article written in 1934 for American consumption,^{11/} emphasized the advantages accruing to the public and to the medical profession from the health insurance system, and the interest of both of these groups in extending the system. He stated that:

In conclusion, if, as the result of the British experience, one were to offer any advice to members of the profession or other persons interested in public health elsewhere, one would feel inclined to say with a good deal of emphasis, that, whatever variation there might be in many details of any proposed insurance health

^{9/} Report of the Royal Commission on National Health Insurance, His Majesty's Stationery Office, London, 1928.

^{10/} The British Medical Association's Proposals for General Medical Service for the Nation, Office of the Association, London, 1930.

^{11/} "Health Insurance in England", Sir Henry B. Brackenbury, New England Journal of Medicine, April 12, 1934.

service, certain conditions should be regarded as essential for smooth working and success.

First, the three unusual features of the English scheme mentioned above should be regarded as absolutely fundamental - the right of all doctors to be members of the service; the absence of interference between doctor and patient as such when once this relationship has been brought about; the close and appropriate association of the profession itself with the administration.

Secondly, the scheme for provision of medical benefit (i.e., medical advice and treatment) should be separated as complete as possible, both financially and administratively, from any insurance provision for cash payments of any kind.

Thirdly, the scheme should, from the beginning, make provision for a full medical service, not merely for general practitioner attention but also for consultant, specialist, and other ancillary services, and, where circumstances allow, for institutional treatment also....

Fourthly, the scheme should be administered as simply as possible in topographical areas, and not through a multiplicity of "approved societies"....

Most of the difficulties and complications that have from time to time arisen under the existing English scheme have been due to the fact that these last three conditions have not been fulfilled; and the British Medical Association in the spring of 1930 issued "Proposals for a General Medical Service for the Nation," incorporating the above stated general principles and urging the extension of the sickness insurance law to cover not only the insured employees themselves but also the members of their families, to provide the services of specialists as well as of general practitioners, and to arrange for hospital care, as measures for increasing the provision which the present law furnishes for attending to the health of the people by securing full medical attention for them.

Beveridge plan. In 1942, the Beveridge Plan proposed an extension of insurance to include comprehensive medical services for the entire population.^{2/} Two years later, the White Paper on National Health^{3/} proposed a revision of National Health Insurance with these same two objectives. There has been much controversial discussion of these proposals in both lay and professional circles. The need for extension of the National Health Service is not questioned; neither is the proposed provision of comprehensive medical services. The cruxes of the controversy are: first, whether coverage should be extended to dependents of currently covered workers and to others in the same financial status so that 90 per cent of the population would be protected, or whether the entire population, including the 10 per cent in the upper income brackets, should be covered; and second, whether the administrative machinery proposed in either the Beveridge Plan or the White Paper would adequately protect the independence of the medical profession.

At the 1944 Annual Representative Meeting of the British Medical

Association, the official opinion of the body on an extended health insurance system was expressed as approving

....inclusion of all existing and future civilian medical services...(and) its extension to dependents....and others of similar economic status. (It was insisted that) the following fundamental principles be incorporated: a. Freedom of choice of patient and doctor. b. Non-intervention in professional matters of any third party in the doctor-patient relationship. c. Medical representation at all levels of administration by election of the profession. d. The evolution of a National Health Service must be by steps, and governed by the availability of medical personnel.^{12/}

Although the British Medical Association Annual Representative Meeting disapproved extension of the insurance to 100 per cent of the population,^{13/} this does not appear to be the consensus of the entire medical profession. The British Institute of Public Opinion (Gallup Poll), at the request of the British Medical Association, sent survey forms dealing with the proposed extension of health insurance to 54,000 physicians, of whom 48 per cent replied.^{14/} In answering the question "should coverage (of compulsory insurance) be 90 per cent or 100 per cent of the population," 60 per cent of all replies, and 73 per cent of the replies from physicians in the armed services favored coverage of 100 per cent of the population. Because only a small proportion of physicians in the armed services were able to reply, and because the replies of such physicians differed from the total, it may be inferred that, had more armed services physicians been able to reply, the total result in answer to this question would have been at a point somewhat greater than 60 per cent.

A further indication of the trend of thought of the medical profession is found in the report of Medical Planning Research,^{15/} an organization of 400 anonymous British physicians, most of them under 45 years of age, and representative of all classes in the medical profession. The report approved universal coverage by a comprehensive, nationally-organized health service. Non-medical thinking on the subject of extension of national health insurance as proposed in the Beveridge Plan and the White Paper is generally favorable. For many years, representatives of labor have been urging extended benefits and coverage. The Labor Party Confer-

^{12/} Journal of the British Medical Society, December 23, 1944

^{13/} This is based largely on the fear that private practice will become non-existent.

^{14/} British Medical Journal, August 5, 1944 Supplement, and September 16, 1944 Supplement.

^{15/} "Interim General Report of Medical Planning Research", The Lancet, London, November 21, 1942. Published in United States by Medical Administrative Service, Inc., New York, 1943.

ence adopted without dissent a motion welcoming the White Paper as an essential part of a social security scheme.^{16/} Representative of thinking of a different section of the non-medical population is the resolution of the London County Council welcoming the White Paper proposals as an advance towards a full health service for the people.

Thus the health insurance issue in Great Britain is not whether benefits and coverage should be extended, but whether coverage should be extended from 40 per cent of the population to 90 per cent or 100 per cent, and what form the administrative structure should take.

New Zealand

There has been considerable newspaper publicity concerning New Zealand's medical insurance program, which is pertinent at a time when many individuals and organizations who have been consulted on the subject of medical insurance warn against abuse and excessive use of services, especially physicians' home and office visits paid on a fee basis. Much of the information played up in the newspapers deplores the present system. In a dispatch which appeared in the New York Times of November 7, 1945, the following criticisms were leveled against the plan: racketeering by some physicians, who collect fees without even seeing their patients; great inflation of the earnings of doctors, which are easily concealed; state stimulus of the practice of collecting large sums for little medical work; disinclination of physicians to care for difficult cases in home and office, with consequent referral to hospitals; and illegal gains by country doctors under the system of paying mileage charges.

It seems probable that all of these abuses are encountered in some measure. Mr. Sydney Greenbie, former special assistant to the American Minister to New Zealand, in a letter to the editor which appeared in the New York Times of November 19, 1945 agreed that abuses exist but claimed that the newspaper account of November 7 was "a distortion of the program and its intentions." It is true that the operation of the New Zealand plan is proving more costly than was anticipated. In an article in the Wellington, New Zealand Evening Post of October 6, 1945, the Minister of Health was quoted as saying, during a discussion of the Health Department's estimates:

I am bound to say that the abuse of the fee-for-service is causing the Government to consider seriously whether that system should be continued.

The Minister also said that there was too much hospitalization under the

^{16/} British Medical Journal, January 6, 1945 Supplement.

medical insurance program; the Government had hoped that fee-for-service for home and office care would discourage hospitalization, but that it had not worked out that way.

The accounts appearing in newspapers in this country, and the Minister's statement quoted above, have led many people to the conclusion that the New Zealand government was planning to abandon its medical insurance system. There seems to be no justification for such a conclusion because, on December 21, 1945 the Minister of Health wrote as follows to a correspondent in this country:

I have received your two letters of 9th October and 8th November regarding articles published in your press about the New Zealand health services.

My reference in the House of Representatives, which was not fully quoted in the articles referred to, was a reference entirely to abuses which had occurred in our fee-for-service system, and I suggested that this particular method of payment might have to be abandoned unless the abuses were corrected. I should point out that there are several methods of remuneration available under our extensive health scheme, and it was certainly not suggested that the entire scheme should be jettisoned. On the contrary, active steps are being taken to extend it, and at present discussions to this end are being carried on with the New Zealand Branch of the British Medical Association. In particular, it is probable that specialist services, which so far have not been the subject of benefit under the Social Security Act, will be included as a benefit next year. The profession have also given an undertaking that they will take active steps to discipline those few of their members who have been abusing the fee-for-service portion of the general practitioner scheme.

In view of the conflicting statements on the New Zealand plan, the Commission staff made a dispassionate appraisal from data obtained from the New Zealand Legation, and from Jacob Fisher's review in the Social Security Bulletin of September 1945.

Revenues. New Zealand's medical program is a part of an extensive social security system including old age and survivors insurance, family benefits, unemployment benefits, and temporary and permanent disability benefits. All are financed by a 5 per cent tax on the gross income of individuals and the net income of business firms, a nominal social security registration fee applying with few exceptions to all persons over age 15,^{17/} and a deficiency grant from general funds. Table 7 shows the sources of revenues for the year 1942-43. In the description of the New Zealand plan upon which this memorandum is based, fees and costs are given in pounds, shillings and pence, which may be somewhat confusing. The pound has been fixed at \$3.24 at the current rate of exchange, but in terms of 17/ 5s. annually for women, and men aged 16-20; 5s. quarterly for men over age 20.

Table 7. Receipts of New Zealand Social Security Fund, 1942-43

Source	Amount (pounds)	Per cent of total
Social security income tax		
On wages and salaries	7,548,391	47.1
On company income	1,403,475	8.8
Other	2,672,180	16.7
Registration fee	540,921	3.4
From general funds	3,800,000	23.7
Penalties, etc.	48,673	.3
Total	16,013,640	100.0

purchasing power in New Zealand its value would seem to be much greater. Comparing the average wage for male workers in industry in New Zealand and in New York State (\$55), it ap-

pears that the relative value of the New Zealand pound is \$7.90, the shilling \$0.395, and the penny \$0.0329 ^{18/} Whether or not this adjustment is exactly correct, it is suitable for purposes of comparing New Zealand costs with those of plans that have been studied by the Commission for New York State.

Historical background. Prior to 1938 about 20 per cent of the population was enrolled in friendly societies (voluntary plans), the remainder obtaining care privately on a pay-as-you-go basis. However, there were large governmental subsidies to hospitals (most of which were public hospitals), and out-patient departments functioned on a much larger scale than they do in this country. Substantial government aid was given for infant and maternal health services, free school health services were well developed by 1938, and dental treatment of school children dated back to 1919.

Coverage. All residents are covered without regard to financial status.

- Benefits.
1. Medical - home and office. This benefit consists of home and office care provided, except for a few panel and salary physicians, on an indemnity basis. The authorized services embrace all care by general practitioners and specialists, exclusive of examination to obtain a medical certificate, dental extractions, and care of workmen's compensation cases.
 2. Maternity - home, office and hospital. This differs from medical benefits in that it covers care by private physicians in home, office or hospital. It is on a service basis, except that private hospitals and certified specialists may make an extra charge.
 3. Medical - hospital out-patient departments. Hospital out-patient departments provide medical and surgical

^{18/} In a later communication, Mr. Fisher has stated that he believes the values should be somewhat higher: pound \$8.30, shilling \$0.415 and penny \$0.0345

care without any charge, thus guaranteeing everyone care without additional cost, if he wishes to avail himself of it.

4. Hospital - including physicians' services. This benefit consists of an indemnity of 9s. (\$3.55) per day for care in licensed private hospitals, which sum must be accepted by such hospitals as a partial payment. It also consists of payment of 9s. (\$3.55) per day for care in public general hospitals, which sum must be accepted by public hospitals as full payment for hospital care, which includes physicians' medical and surgical services, and x-ray and laboratory examinations in the hospital. Care in tuberculosis, mental and other special hospitals, and in the hospital wards of homes for the aged, as well as in general hospitals, is included. There is no limit on length of stay.
5. Pharmaceutical. This includes, on a service basis, all necessary drugs, supplies and appliances prescribed by a physician.
6. X-ray. Diagnostic services as recommended by the attending physician may be obtained on an indemnity basis from a recognized radiologist, or on a service basis from public hospitals.
7. Massage (physiotherapy). Physiotherapy service, on an indemnity basis, as recommended by the attending physician.
8. Visiting nurse service. Nursing service in the home by nurses in the employ of voluntary agencies, hospitals and the health department.

Provision of benefits. The system permits medical benefits, home and office, to be supplied by salaried physicians, or on a capitation basis, or on a fee-for-service basis. Of about 800 general practitioners, 16 who are in sparsely settled areas are on a salary basis. Fewer than 50 physicians agreed to capitation when this system was introduced in 1941, and the number may be even smaller at present. The remaining general practitioners are on a fee-for-service basis. There is free choice of hospital. As noted above, extra charges may not be incurred for either hospital care or physicians' services in public hospitals, whereas care in private hospitals is on an indemnity basis. With few exceptions, the private hospitals are maternity hospitals and nearly all of them participate in the program. Of 201 private hospitals participating in March 1943, the Social Security fee was accepted as full payment by 31, an additional charge might be made to the patient in 139, and the right to charge the patient for accommodations not covered under the contract was exercised by 31. Almost every obstetrical nurse, physiotherapist, pharmacist and visiting nurse

participates in the plan.

Payment for benefits. The rates of payment for various services are shown in Table 8. By our standards, payment for services seems adequate. In considering the rate of payment to hospitals, it must be realized that in 1943-44 local public hospitals received about 1 million pounds in subsidies from the Dominion and 1 million pounds from local taxes, in addition to 2.3 million pounds from patients (2.13 from insurance fees), and 0.3 million pounds from miscellaneous sources.

Table 8. Rate of Payment for Benefits under New Zealand Plan

Service ^{a/}	Fee ^{e/}
Home or office visits, general practitioner or specialist	7s.6d. \$ 3.96
As above, nights or Sundays	12s.6d. 4.94
Physician, capitation basis <u>d/</u>	15s. 5.92
Delivery by physician, including prenatal care	126s. 49.77
Delivery by physician, no prenatal care	84s. 33.18
Per diem to general hospitals <u>b/</u>	9s. 3.55
Payment to mental hospitals (lump sum)	
To hospital, for maternity <u>c/</u>	
Day or days of labor	45s. 17.58
Subsequent days	12s.6d. 4.94
Physiotherapy, per treatment	3s.6d. 1.38

a/ Services in out-patient departments of public hospitals are paid for on a lump-sum basis; pharmaceutical and x-ray benefits are paid for according to price schedules; visiting nurse service is paid for at an arranged rate.

b/ Public hospitals receive Federal and local subsidies, also.

c/ Public hospitals receive an additional 40s. for medical attendance.

d/ Exclusive of mileage allowance.

e/ Rates paid to salaried physicians are unknown.

The system of paying physicians on a fee-for-service basis involves three different arrangements.

1. The physician may bill the government monthly for payment at the established rate, submitting forms signed by the patient certifying to the service given; he accepts the government rate in full payment of the services rendered.
2. The physician bills the government at the established rate, but charges the patient a fee in excess of the government rate. However, except in special circumstances he cannot recover by legal process any excess charge.

3. The physician bills the patient as in private practice, charging either the government rate or a larger fee. In either case, the patient pays the doctor directly and sends the receipt to the post office for a refund at the government rate.

Administration. The medical insurance program is administered by the Federal Health Department, but the medical insurance provisions are administratively and financially separate from such orthodox public health services as communicable disease control, sanitation and health education.

Evaluation. The New Zealand plan was developed progressively, and figures on expenditures over a period of years must be interpreted accordingly. Table 9 lists medical insurance expenditures in the period 1939-44. Table 10 lists the dates when various benefits became available.

The progressive increase in expenditures is due to a number of factors in addition to increase in usage of service. For example, the capitation method of payment for general practitioner service was begun March 1, 1941, but was accepted by less than 50 physicians. The fee-for-service method of payment for general practitioners was not authorized until November 1, 1941, and at the outset the New Zealand Branch of the British Medical Association instructed physicians to charge their regular fee, leaving to the patient the responsibility of obtaining by refund the government-fixed fee. Some months elapsed before a majority of physicians participated in the plan, but recently more and more physicians have been cooperating. Up to April 1943, hospitals were paid at the rate of 6s. (\$2.37) per day, at which time the rate was raised to 9s. (\$3.55)

Although it appears that the per capita cost for the program is \$22.83, (\$32.50 if local and federal subsidies to hospitals are included), the population being 1,635,715,^{19/} it must be realized that expenditures for the hospitalization of tuberculosis and mental disease and for drugs are included, which costs must be disregarded if a comparison is to be made with the cost figures estimated for New York State. Also, the differing provisions with regard to physicians' services in the hospital make it necessary to disregard the total figures and to base comparisons on individual benefits. The figures employed herein relate to the cost of benefits, exclusive of administration.

The cost of general practitioner service is about \$6.50 per capita, as compared with a figure of about \$10.00 estimated for New York State. X-ray amounts to \$0.53 per capita, as compared with about \$0.75 to \$1.10

^{19/} The annual report of the New Zealand Department of Health for the year ended Mar. 31, 1944 gives a population of 1,635,715. The figure employed by the New Zealand authorities is very slightly lower, their per capita figure being 57s.10d, or \$22.84

Table 3. Expenditures Under New Zealand Medical Insurance Plan, 1939-40
Through 1943-44, in Thousands of Pounds

Service	1939 -40	1940 -41	1941 -42	1942 -43	1943 -44
Maternity benefits	283.8	519.0	549.9	505.2	513.9
Hospitals					334.6
Medical practitioners					167.3
Obstetrical nurses					12.0
General practitioner services			205.7	1,016.0	1,179.3
Capitation method					55.6
Fee-for-service					1,026.1
Special arrangements					37.2
Mileage					60.4
Hospital benefits	772.9	1,257.7	1,372.4	1,539.3	2,133.4
Public hospitals					1,536.6
Private hospitals					238.8
Mental & other State					238.0
Other institutions					43.9
Out-patient benefits					73.1
Other					3.0
Pharmaceutical benefits			279.7	563.2	762.2
Chemists and medical practitioners institutions					722.2 40.0
Supplementary benefits			28.0	97.4	137.7
X-ray diagnosis					109.4
Massage					27.3
Other					1.0
Total	1,056.7	1,776.7	2,435.7	3,721.1	4,726.5

Table 4. Chronology of Development of New Zealand Medical Insurance Plan

Service	Date inaugurated
Care in mental hospitals	April 1, 1939
Maternity benefits	May 15, 1939
Hospital in-patient benefits (hospitals paid 6s.)	July 1, 1939
Capitation to physicians	March 1, 1941
Hospital out-patient benefits	March 1, 1941
Pharmaceutical benefits	May 5, 1941
X-ray diagnosis benefits	August 11, 1941
Fee-for-service to physicians	November 1, 1941
Massage (physiotherapy) benefits	September 1, 1942
Hospital in-patient benefits (hospitals paid 9s.)	April 1943
Visiting nursing benefits	July 1944

estimated for New York State.

Apparently, an average of 1.7 general practitioners' visits are given per person per year. This may be compared with rates of about 2 visits per year for persons of moderate means in New York and Chicago, and 2.2 per year for persons of moderate means in towns of 5,000 or less in the United States.^{20/} It is about one-half of the number under the British system described earlier in this chapter. The low rate of visits per person may be attributable to the high rate of hospitalization. The data do not disclose whether there has been any great increase in the rate of physicians' visits under the insurance plan as compared with the rate prior to inauguration of the insurance system. It may be assumed that there has been some increase, and that an increase should be considered as desirable, provided the volume of services does not exceed that required for adequate medical care. In other words, an increase within such limits indicates that people are obtaining necessary services for the first time, owing to removal of the financial barrier by the insurance plan.

Certain instances of abuse have been cited. For example, a doctor was accustomed to make periodic checkups on the inmates of a public institution, for a salary of 150 pounds per year. Under the medical insurance plan, the doctor is said to have made one visit a week to the institution, where he looked over the inmates, gathered signed statements from them and collected 1200 pounds per year for the same work. In another case, a physician checking up on 300 children at a summer camp was able to collect 112 pounds for two hours' work. In country districts, doctors arranged their calls so that they collected more in mileage than was warranted by the actual distance traveled.

The number of physicians participating is believed to be about 800, which would give them an average income under the plan of 1,683 pounds (\$13,300 gross or \$7,980 net) exclusive of x-ray services, or 1,820 pounds (\$14,400 gross or \$8,600 net) including x-ray services.^{21/} A low ratio of physicians to population tends to inflate salaries somewhat and to make the services rendered somewhat cursory. This is a situation which can only be corrected by an increase in the number of physicians with the passage of time. The three situations in which abuses seem to occur in re-

20/ Medical Care and Costs in Relation to Family Income, Margaret C. Klem and Helen Hollingsworth, Bureau Memorandum No. 51, Social Security Board, March 1943.

21/ This gross income may be compared with that of general practitioners in the United States in 1943, which averaged \$12,554, according to Medical Economics, 23:50-54, October 1945.

spect to physicians' services are: medical inspection of groups, care of inmates of such institutions as homes for the aged, and mileage allowances, all of which should and could be controlled by appropriate administrative measures.

The direct cost to the insurance plan for general hospital care, including physicians' services in the hospital is \$8.59 per capita, which seems low when compared with the cost of \$14.55 for similar services as estimated for New York State. However, to this must be added about \$9.66 per capita in the form of federal and local subsidies to public hospitals, giving a total of \$18.24 per capita. A great part of this relatively high cost seems to be due to the high degree of hospital utilization, which is 2.3 days per capita. This is greatly in excess of the actual rate of 1.24 days for New York State in 1944, and greater than the maximum utilization of 1.38 days anticipated if the economic barrier to hospitalization were removed.

For reasons which are not readily apparent, sparsely settled areas use more hospital service than do densely settled areas,^{22/} but after allowance for this factor, a substantial difference remains. Mr. J. S. Reid, First Secretary of the New Zealand Legation, stated on December 10, 1945 that a satisfactory comparison cannot be made because of national differences in the historical role of the hospital in the provision of medical care. The days per capita in governmental general and maternity hospitals in New Zealand was 1.90 in the year 1943-44, and 2.30 days after allowing for private hospitals. The United States figure corresponding to the latter was 1.59 days. The difference may be accounted for in part by the fact that the stay in governmental hospitals is considerably longer than in private hospitals, being in both countries a little under 3 weeks, and that governmental hospitals account for 82 per cent of all beds in New Zealand, but only 66 per cent in the United States. Mr. Reid believes that the difference is not necessarily associated with the availability of hospital benefits, and compares data for 1938-39, the last complete year prior to the inauguration of maternity and hospital benefits, with 1943-44. In 1938-39, patient days in general and maternity hospitals in New Zealand (governmental only) averaged 1.30 per capita, and in the U.S. 0.87 (governmental and non-governmental). Between 1938-39 and 1943-44, patient days increased approximately 50 per cent in New Zealand and approximately 85 per cent in the United States, the increase in both coun-

^{22/} Hospital Survey Newsletter, October 1945, Commission on Hospital Care, Chicago.

tries being related in large measure to the growth of the armed forces. Perhaps the only conclusion that can safely be drawn with regard to hospital utilization is that although a compulsory insurance plan may not of itself increase the rate of hospital utilization, other factors may continue to operate and increase the rate.

Insofar as data are available and are interpreted objectively, it appears that the New Zealand plan is basically sound administratively and financially. The abuses noted seem easily susceptible of correction, and although deviation in a few respects might be desirable, the plan might well serve as a model for a modern, comprehensive medical insurance plan.

Proposed State and National Plans

A number of State and national plans which are of current interest because of widespread publicity or because of unusual features are summarized briefly in this section.

Arkansas. The Hollingsworth State Hospital System Act was placed before the electorate in 1944, and defeated by a vote of 44,333 for and 142,554 against. The purpose of the plan was to provide hospitalization at State expense for charity (relief) patients, to materially reduce by State tax funds the cost of hospitalization to all others, and to furnish low-cost diagnostic service to all without regard to ability to pay.

Services and facilities were to be provided by a system of State-owned and operated hospitals and clinics. No attempt was made to utilize existing facilities or integrate the new facilities with them, and administration was required to be controlled by a non-professional board.

Revenues were to be derived indirectly, by a tax on lumber, coal, oil, minerals, etc. produced in the State, and by a tax on the manufacture of electric current, except that generated by a municipality for its residents. A majority of beneficiaries would have to pay part of the costs directly from their own resources.

The only medical benefit to be provided was clinical diagnostic service, at the cost of the "materials." (Incidentally, clinical diagnostic service under public auspices has frequently been recommended for adoption in New York State). For curative services, patients would find it necessary to engage and pay private physicians. The plan had much to recommend it, but suffered from administrative faults and the failure to integrate the public and private hospitals.

Rhode Island. At present, Rhode Island is the only State that has adopted compulsory health insurance, the benefits being limited to cash payments for absence from work due to illness. In 1944, Governor McGrath proposed a plan to cover the same group (persons covered by the State Unemployment Compensation Law), and their dependents under 19 years of age, for hospitalization benefits.

The plan, which was to be administered by the State Unemployment Compensation Commission, was to be financed by a tax of \$1.00 per month on all employed persons, one-half to be paid by the employer and one-half to be deducted from the pay of the employee. This sum would cover employee, spouse and children under 19. If a person left covered employment he could continue his insurance by paying \$1.00 per month directly. Employers might be exempted from the tax upon presenting evidence that all of their employees and their dependents were entitled to equal benefits under some other plan. From the revenues of the plan, the State Division of Public Assistance was to pay hospitals for the care of all persons unable to provide it for themselves. The benefits were about the same as those provided by Blue Cross plans.

The plan may be criticized for not covering domestic and self-employed workers, etc. The contributions were not graded in accordance with ability to pay. Moreover, revenues would be insufficient to cover both employees and their dependents, and the indigent. To judge by newspaper editorials, the public favored the plan, not only because of its benefits, but to forestall Federal action in this field. Since the proposal contemplated that the existing Blue Cross plans would administer the benefits, the Blue Cross organization was in favor of it. The State Medical Society questioned the feasibility of immediate operation of the plan, feared encroachment upon individual initiative and self-reliance, and felt that private insurance companies should not be left out. The Medical Society's counter-proposal was for a Voluntary State Health Council, to be appointed and directed by the President of the State Medical Society, to study all aspects of health. A Voluntary Advisory Council on Health was finally appointed by the Governor. The Council later reported that because of a possible shortage of hospital facilities, and because of an increased Blue Cross enrollment, the State should defer any action, and the proposed hospital insurance law did not come to a vote.

Massachusetts. Legislative and other groups facing the acknowledged need and public demand for a system of medical insurance which would be

within the financial means of at least a majority of the population have sought some method which would be short of compulsion. Proposals have been made repeatedly for governmental subsidy of existing voluntary medical and hospital insurance organizations. Such proposals have not been deemed acceptable because, first, they entail the use of public moneys for the benefit of a limited group selected not on the basis of need, but on the basis of having voluntarily paid a premium to an insurance organization, and, second, because the constitutions of many States (as in New York) prohibit the loan or gift of State funds to any private individual or corporation.

In Massachusetts, the Committee on Labor and Industries of the House of Representatives, to whom were referred numerous petitions and bills for the establishment of systems of cash sickness benefits and medical insurance, in 1945 reported in a bill (House No. 1923) which sought in another fashion to materially extend medical insurance on a "voluntary" basis.

The bill, which applied only to employers of 10 or more persons, provided that if 75 per cent of the employees of a firm recorded their wish to be covered by this type of insurance, the employer would be obliged to furnish it and pay one-half of the cost. Governmental, farm and domestic employees were excluded, and any individual employee might be excluded if he wished. Dependents were not covered.

Benefits, available only during the period of regular employment, would be:

(a) Cash benefits amounting to two-thirds of weekly wage up to \$20 per week, for a maximum of 13 weeks in each illness; (b) hospital expense up to \$4.75 per day for a maximum of 30 days in each illness; (c) a \$25 allowance toward costs of operating room, x-ray, laboratory service and anesthesia; (d) surgical costs according to a fee schedule, with a maximum of \$150 for any one operation; (e) maternity cash benefits of two-thirds of weekly wage up to \$20 per week for a maximum of 6 weeks, \$4.75 per day for hospitalization for a maximum of 10 days, and physician's obstetrical fee of up to \$50. No benefits would be paid which would duplicate those received under Workmen's Compensation or Unemployment Insurance.

The insuring agency might be the employer as a self-insurer, or a private company, or a non-profit medical or hospital service corporation. Poor insurance risks not acceptable to insurance companies would be divided by the State insurance commissioner among companies writing health insurance. The premiums were not fixed by law and would be whatever the insurance organization or employer found it necessary to charge. A division of sickness and health insurance in one of the State departments would administer the law.

The bill is open to criticism because the term "voluntary" in its title is misleading. Although voluntary for the employee, it would be compulsory upon the employer. Employers having to pay one-half of the cost of insurance might be at a competitive disadvantage. The individual cost would vary markedly, depending upon the proportion of females employed. Some employers might be inclined to influence employees against voting for insurance. Coverage would be limited to the employees of larger establishments, and farmers, domestics and governmental employees would be excluded. Also, dependents would not be covered. Enforcement of the law would be difficult because of the method of securing insurance, and the payroll deduction by each employer of a different amount. Risks and premium rates would vary greatly from firm to firm. There would undoubtedly be many instances in which companies would refuse to write policies at rates agreeable to the employer, and it would be necessary for the State to require companies to underwrite unfavorable risks, a situation which might prove awkward.

California. Several bills proposing a health insurance system were before the Legislature in 1945. The two most important were the one sponsored by Governor Warren, which is described below, and one sponsored by the State CIO, which differed only in that the indigent were to be included and that general practitioners were to be paid on a capitation basis.

The Governor's bill (AB 800) would cover on a compulsory basis all employees under the State Unemployment Act, non-Federal government employees, and dependents. Railroad and maritime employees, agricultural laborers, domestic servants in private homes, and Federal employees would be excluded. An employer not covered by the bill might voluntarily obtain insurance for his employees and their dependents, and the State could issue insurance to other individual residents and families who might wish to join.

The plan would be financed by a payroll deduction tax, $1\frac{1}{2}$ per cent on the employer and $1\frac{1}{2}$ per cent on the employee, on the first \$4,000 of annual earnings. Additional moneys which might be needed would come from State general funds.

A subscriber and his dependents would be eligible for service throughout a calendar year if the employee received at least \$300 in taxable wages for the first four of the last five completed calendar quarters. Eligibility would continue for thirty days during periods of

unemployment, or until recovery from an illness which occasioned termination of employment. Workmen's Compensation, tuberculosis and mental cases would not be covered.

The benefits would include general practitioner services, consultation and specialist service, laboratory and x-ray service, hospital care of not more than 21 days per year for each separate illness, preventive medicines and drugs for ambulatory patients, all medicines and prescribed supplies for hospitalized patients, general hospital nursing, and dental service for extraction, treatment of infection and fracture. By regulation the benefits might be restricted, or additional benefits consisting of increased hospital stay, additional drugs, added dental and medical services, and optometric services might be provided. Freedom of choice among registered professional persons or groups would be guaranteed.

The system would be administered by an Authority composed of a Manager (not necessarily a physician), the State Director of Public Health, three representatives of employers, three representatives of employees, three licensed physicians (one experienced in hospital management), and one licensed dentist.

The benefits would be paid for on a fee-for-service basis. Charges to beneficiaries in excess of the established fee schedule were neither sanctioned nor prohibited.

The plan would seem to be a workable one. Although subject to criticism because compulsory coverage would be limited, some provision would be made for voluntary insurance for others. Professional representation would seem somewhat deficient, extending only to four of the twelve members of the Authority, and to an advisory board. Also, the chief administrative officer would not be required to be a physician. The rate of contribution would be somewhat low; if it were necessary to raise a substantial sum through general taxes, they would also fall upon persons not receiving benefits.

New York (Ives Bill). A compulsory health insurance bill (A.2542) was introduced in 1945 by Assembly Majority Leader Irving M. Ives, who is also Chairman of the Joint Committee on Industrial and Labor Conditions. Mr. Ives is reported as declaring that it was not introduced for immediate passage, but to serve as a basis for hearings and discussions by the Joint Committee on Industrial and Labor Conditions, with a view to drafting perfecting amendments and obtaining its approval by the Legislature in the following year.^{23/}

^{23/} New York Times, March 8, 1945.

Coverage would be the same as for Unemployment Insurance, i.e., all employees of employers with four or more workers for at least fifteen days during the year. Farm laborers, employees of governmental and non-profit organizations etc. would be excluded. Coverage would extend to the employee's dependent spouse, minor children or parents. For revenues, the employer and employee each would pay a 1 per cent tax on the first \$3,000 of earnings.^{24/} Deficits would be made up from the general funds of the State.

Any person who would receive unemployment Insurance if unemployed (provided he has earned at least \$100 in covered wages in each of the last two consecutive calendar quarters), and the dependents of such person would be eligible for benefits. If the employee were out of work, eligibility would continue for the period of Unemployment Insurance benefits and for thirty days thereafter. Once authorized for an eligible person, benefits would be provided until recovery or for a period of up to one year ~~for~~ any one illness, no matter how long the person might be unemployed due to such illness.

The benefits would include: general practitioner for preventive, diagnostic, therapeutic or other medical care or treatment, and for annual general physical examination; consultation and specialist service; laboratory and x-ray service; hospitalization up to 21 days per year for one illness; preventive medicines and drugs for non-hospitalized cases; all drugs and appliances for hospitalized cases; general nursing services; and dental service for extractions and treatment of acute infections.

Additional services which would be made available by the administrator (State Industrial Commissioner) if funds were sufficient would be: increased period of hospitalization, additional drugs and appliances, optometric service, and additional medical or dental service. Workmen's Compensation, tuberculosis and mental cases would be excluded. The Industrial Commissioner might restrict basic services in respect to the first treatment by physician, and home calls; i.e., if the Fund ran into financial difficulties, home care might be entirely excluded, and patients might be required to pay for the first visit to a physician.

The plan would be administered by the State Industrial Commissioner, who would make necessary arrangements for provision of service and payment therefor. He would be authorized to pay physicians on a fee-for-

^{24/} If an employee worked for more than one employer in the year, each employer would pay a 1 per cent tax on the first \$3,000 he paid to the employee.

service, capitation or salary basis, as he might desire. The Industrial Commissioner could enter into contracts with hospitals, groups or associations of employers or employees, fraternal, charitable or other non-profit organizations for furnishing all or a part of the prescribed benefits; or with an employer for rendering service to his employees and their dependents. Payments to such groups would be based on the amount of contributions made by employee and employer in behalf of the individuals covered. No employer could require membership in a health system as a condition for employment.

In appraising this type of plan, limitation of coverage to 60 per cent or less of the population, and the method of financing may be questioned. Table 11 shows the anticipated income and a conservative estimate of expense. The tax on employer and employee would provide only

Table 11. Anticipated Income and Expense of State Health Service Fund
(in Millions)

Year	Income			Expense ^{a/}	Deficit	
	Employer	Employee	Total		Amount	Per cent
1940	\$48.0	\$48.0	\$96.0	\$225.8	\$130.8	53
1941	56.3	56.3	112.7	250.4	137.7	55
1942	66.9	66.9	133.8	274.1	140.3	51
1943	77.2	77.2	154.4	283.5	129.1	45
1944	81.3	81.3	162.5	283.5	121.0	43

^{a/} Based on coverage of only 70 per cent of employees, i.e., those with earnings of \$500 or more annually; average family of 2 persons; and annual per capita cost of \$33.75 (as in Health Insurance Plan of Greater New York)

42 to 57 per cent (or less) of the sum needed, the remainder coming from general taxes. Thus the entire population of the State would be taxed to provide a substantial proportion of the benefits from which 40 to 50 per cent of them would be excluded; in fact, some of the beneficiaries would be non-residents. This is contrary to the social insurance principle that premiums collected should completely finance the program, as in Unemployment Insurance and Old Age and Survivors Insurance. Also, the payroll tax of 1 per cent on New York State employers might place them in an unfavorable competitive position with out-of-State employers not subject to such a tax.

A further criticism is that too much unrestricted authority would be given to the Industrial Commissioner, who would set rates, restrict or expand basic services, approve hospitals, set standards for services, etc. No provision is made for representation of the persons receiving or rendering service.

New York (Austin, Jack, Joseph Bills). Essentially identical compulsory health insurance bills were introduced in 1945 by Assemblyman Jack (A. 141), Senator Joseph (S. 479) and Assemblyman Austin (A. 261). All employees and their dependents would be covered on a compulsory basis. Any resident not covered under compulsory insurance might obtain voluntary coverage for medical benefits only:

- a. For himself and his dependents without a health examination,
 - (1) if not suffering from any disability and covered at least four quarters in the past three years, or
 - (2) if involuntarily unemployed and covered one year of the past three; or, if not so covered
- b. For himself after passing a health examination and for those of his dependents passing a health examination,
 - (1) if under 65 and not suffering any disability, or
 - (2) if receiving unemployment or old age benefits or public relief, and the responsible agency will pay the premium.

Under compulsory insurance, the employer and the State would each pay a tax of 1 per cent of the payroll. The employee would not be taxed. The employer would be prohibited from passing any part of his tax on to the employee. Under voluntary coverage, subscribers admitted under a-2 and b-1 would pay 1 per cent of annual earnings, and under a-1, \$120 annually. Under b-2, a premium set by the Health Insurance Board would be paid by the public agency. The State would contribute an amount equal to 1 per cent of the annual earnings of each voluntary subscriber.

After 7 consecutive days of disability an employee would be eligible for cash benefits payable up to 26 weeks. The benefits would be similar in amount to Unemployment Insurance. They would not be payable while payments were being received under Workmen's Compensation or public assistance.

If a woman had worked in covered employment, or if her husband had worked in covered employment but had become unemployed, she would be entitled to cash benefits at the rate of general disability cash benefits for six weeks before and after birth of a child, providing she did not work during that time. If prenatal care had been received by an eligible mother, \$25 would be paid at birth of a child.

Medical benefits would be available to insured persons currently covered, or covered by the plan in the previous 24 months. They would include^{25/26/}: general practitioner, not to exceed 26 weeks in one illness; general or special hospital care to a maximum of 111 days for one

^{25/} If sufficient funds were not available, benefits might be reduced temporarily.

^{26/} Persons leaving covered employment and taking voluntary coverage within four weeks (a-1 and a-2) might use these services without limit.

illness (the patient to pay 15 per cent of cost after the first 21 days, and persons 65 or older not being eligible for more than 90 days care in 104 consecutive weeks); services of specialists, diagnosticians or surgeons not to exceed 12 weeks in one illness; laboratory and clinic services not to exceed 12 weeks for one illness; nursing services outside of hospital; and dental surgery for relief of pain.

The following additional services might also be made available by the Board with or without a charge for services: drugs, medicines, ordinary medical and surgical appliances; institutional care for convalescents; special medical, surgical and dental appliances; general services of dental practitioner; services of dental specialists; and extension, in individual cases, of practitioner, laboratory, and specialist services.

The plan would be administered in the State Department of Health by a State Commissioner of Health Insurance under a policy-making Health Insurance Board consisting of the Health Insurance Commissioner (Chairman), the State Commissioner of Health, and 13 members appointed by the Governor to represent: employers (4), employees (4), cooperating medical practitioners (2), specialists (1), dental practitioners (1), and hospitals (1). At the local level (the State would be divided into areas), there would be local councils consisting of 7 persons - the local Finance and Medical Managers, the local public health officer, and representatives of cooperating professions, hospitals, employers and employees. The local councils would supervise local operation of the plan, collect premiums and furnish benefits, and determine the system of remuneration (salary, per capita, or fee basis, or combination of these, with special arrangements possible for group practice), which for general medical and dental practitioners would have to be acceptable to the majority of the participants in each group. The local administrative agency would include advisory committees, a Finance Manager, and a Medical Manager (a physician who would pass on disability, provision of medical services, claims of persons furnishing services, and supervision of quality of services).

One-third of the moneys received under compulsory insurance would be earmarked for cash benefits, and the remainder for medical benefits. It is estimated that an annual deficit of \$250 to \$375 million would be incurred, which would have to be made up from general State funds. This very comprehensive plan was carefully worked out in its administrative details, but seemed to be deficient in respect to coverage of several millions of the residents of the State. No provision was made for participation by Blue Cross and other voluntary plans. Also, it could not

properly be termed an insurance plan, since ~~one~~ but those entering voluntarily would pay any part of the cost directly. Non-residents employed in the State would benefit from general State funds, but would make no contribution. The tax on employers would seem to be simply a revenue device. Difficulties would be anticipated in raising the huge amount to be drawn from general State taxes.

United States (Wagner-Murray-Dingell Bill). In his message to Congress on November 19, 1945, President Truman requested the adoption of a national health program which would include:

1. A national hospital construction program.
2. Expansion of public health, maternal and child health services.
3. Federal aid to medical education and research.
4. A national medical insurance program.
5. A cash sickness benefit program.

The Hill-Burton Bill now before Congress covers hospital construction. A program covering maternal and child health services is found in the Pepper Bill, S.1318. The current Wagner-Murray-Dingell Bill (S.1606, H. R. 4730) covers items 2, 3 and 4, above, and is generally regarded as an expression of the President's views. He estimated that about 4 per cent of the national income would be needed for medical insurance, but left to Congress the determination of the amount that should come from insurance premiums and the amount that should come from general tax funds. It seems likely that in accordance with the President's wishes, a cash sickness benefit program will be the subject of separate legislation, possibly in connection with revision of the whole Social Security Act.

Title I of the Wagner-Murray-Dingell Bill would provide grants-in-aid to States for public health programs, including tuberculosis and venereal disease control; maternal and child health, including crippled children's services; medical care of needy persons; and training of personnel. The Federal government would pay between 50 and 75 per cent of what a State spends for these programs, with the States having the lower per capita incomes getting the greater percentages of Federal aid. Medical care for needy persons might be provided through payment by a State or local agency to the Federal medical insurance system. The United States Public Health Service would administer the public health program, the United States Children's Bureau the maternal and child health program, and the Social Security Board the program for the medical care of needy persons, provision being made for coordination between these and the program for medical insurance.

Title II covers the medical insurance program.

The coverage of the program would be very broad, more so than that of Old Age and Survivors Insurance, and would include perhaps 110 million persons, as follows:

1. All employees in industry and commerce, agricultural and domestic workers, employees of non-profit institutions, and all self-employed persons, and their dependents (spouse, children under 18, disabled adults). Railroad workers, governmental employees, casual laborers, the clergy, employees of foreign governments or foreign merchant marine, etc. would not be covered.
2. All persons receiving retirement or survivors benefits under the Old Age and Survivors Insurance program.
3. Any other person for whom a premium was paid by a public agency. This provision presumably would make it possible for governmental employees to be covered.

The benefits would be very comprehensive, including essentially everything but drugs, but would be subject to restriction to prevent abuse and to conform to the income of the system. Charges to patients in excess of the amounts allowed by the scheduled rates of payment would not be specifically sanctioned or prohibited, except in the case of extra charges for more costly hospital accommodations, which were specifically authorized. Under certain conditions beneficiaries might be required to pay a part of the cost of certain services. The benefits would be:

1. General and special medical care - for which beneficiaries might be required to pay in whole or in part, if necessary to correct abuse.
2. General and special dental care, which would include diagnosis, prophylaxis and extractions as a minimum, but which might otherwise be restricted as to content and age of beneficiaries - and for which beneficiaries might be required to pay in whole or in part, if necessary to prevent abuse.
3. Home nursing care - for which beneficiaries might be required to pay in whole or in part, if necessary to correct abuse.
4. Hospital care, exclusive of tuberculosis and mental disease, limited to 60 days in any one year (but which might be extended to 120 days if sufficient funds were available). Extra payment might be required of beneficiaries for accommodations more costly than the ward type.
5. Laboratory benefits, defined as including x-ray diagnosis and treatment, refractions by an optometrist, eye glasses and other special appliances. Laboratory benefits might be restricted to certain services, or payment of only a fraction of the cost.

All doctors, dentists, optometrists, etc. might participate indi-

vidually, or in groups, or as staff members of a hospital. Registered nurses might participate individually, but practical nurses could work only under a qualified nursing agency. Specialists would be qualified by the Surgeon General of the United States Public Health Service.

All hospitals might participate to the extent that they were approved by the Surgeon General for specified services, but the Surgeon General would be expressly forbidden to supervise or control a hospital, or prescribe its administration, personnel or operation.

The rates of payment to hospitals would be within limits fixed by the law. All other payments would be fixed by the Surgeon General and might vary from place to place.

1. General medical and dental practitioners might be paid on a fee-for-service, capitation or salary basis, as a majority in a given area decided, but the Surgeon General might employ one of the methods other than that selected by the majority to pay those who did not belong to the majority.
2. Groups might be paid by any of the methods described above.
3. Hospitals and their staffs might be paid for inclusive service.
4. Specialists might be paid on a fee-for-service, capitation, salary or per-session basis.
5. Payments for home nursing care would be made to individual registered nurses, or to qualified nursing agencies.
6. Laboratory benefits furnished by a physician or dentist, or by anyone to a hospitalized patient, which were incidental to diagnosis and treatment, would be included in the cost of the diagnostic, treatment or hospital service. Otherwise, payments might be made to qualified individuals other than physicians.
7. Payments for hospitalization might be made to hospitals on a per diem basis, or contracted for on a cost basis. The rates for general hospital care would be \$3 to \$7 per day for the first 30 days, and \$1.50 to \$4.50 for the next 30 days. For care in an institution for the chronic sick the rates would be \$1.50 to \$3.50 per day. Hospitals might require extra payment from patients for more expensive facilities furnished for lack of ward facilities or at the request of the patient, or for services not covered by the contract.

The system would be financed by a self-sustaining fund. The bill would authorize an appropriation but would not specify how the money should be raised.

1. General and special dental benefits, and home-nursing benefits for employed persons covered by the bill, and for persons receiving retirement or survivors benefits under the Old Age and

Survivors Insurance program would be paid for from general tax funds.

2. Hospital benefits, general and special medical benefits and laboratory benefits would be paid for in the following manner:
 - a. An amount equal to 3 per cent of the first \$3,600 of earnings of all employed persons would be utilized to care for such persons and their dependents. (No mention was made of employer contribution, but it is assumed that this would be required.)
 - b. General tax funds would be utilized for the care of persons receiving retirement or survivors benefits under the Old Age and Survivors Insurance program.
3. All benefits for medically needy and other persons for whom a public agency might pay the premium, benefits which might be rendered to Workmen's Compensation cases, and any other benefits that might be contracted for with another agency would be paid for from and to the extent of receipts from such agencies or individuals.
4. Administrative costs for the whole program would be paid for from general tax funds.

The Surgeon General of the United States Public Health Service would administer the medical insurance program. With respect to general policies and rules and regulations he would be required to consult with an official Advisory Council, and to act with the approval of the Federal Security Administrator. He would also be required to cooperate with the Chief of the Children's Bureau. The Advisory Council would consist of the Surgeon General (Chairman) and 16 members appointed by him from panels submitted by professional and lay groups. Local area committees would be established, which would work with the local United States Public Health Service representative and which might submit annual or special reports to the local representative or to the Surgeon General.

The Surgeon General would be authorized to negotiate with, and might utilize local public and private agencies, presumably including State or local health or welfare departments, voluntary, industrial, union, and similar medical and hospitalization insurance plans.

In addition to the program of research and training of personnel which would be carried on directly by him in connection with this program, the Surgeon General would be authorized to make grants-in-aid to non-profit institutions and agencies for research and postgraduate professional education. \$10 million would be authorized for 1946, \$15 million for 1947, and annually thereafter a sum equal to 2 per cent of the benefits of the medical insurance program.

To appraise this program from a financial viewpoint, it may be esti-

mated that in 1942 there were 45 million persons at some time engaged in employment covered by Old Age and Survivors Insurance. If the average number of dependents is roughly estimated at one, about 90 million persons in this category would be covered. This group received \$58.2 billion in wages, of which probably well over 90 per cent, approximately \$54 billion, was under \$3,600. 3 per cent of this amount is \$1.62 billion. The amount available for medical, hospital and laboratory benefits for the group under consideration would thus be about \$18 per capita on the basis of 1942 earnings. Income payments in 1943 were up about one-sixth over 1942, which would yield a per capita of \$21.00, and in 1944 were up one-third over 1942, which would yield a per capita of \$24.00. In calculations for New York State, the full equivalent benefits on a fee-for-service basis would cost about \$27.00 per capita, exclusive of administration. It appears from these rough calculations that sufficient revenues to provide full benefits of this type would require a tax somewhat in excess of 3 per cent unless fees lower than the New York State Workmen's Compensation Schedule and hospital payments lower than those prevailing in this State were employed. However, lower prevailing rates in many parts of the country, and a lack of personnel and facilities in many areas would no doubt make the system financially feasible, especially in view of the provision for limiting medical and laboratory benefits if necessary. Other benefits being provided from receipts or general tax funds, no deficit would be anticipated.

The administrative provisions of the bill may be criticized on the ground that too much power would be placed in the hands of the Surgeon General. It would seem desirable to have more specific statutory provisions, and to have more authority vested in a Federal board with policy-making powers. A greater latitude for decision and administration at the local level would be desirable, and might be afforded by a grant-in-aid program to the States, or a financial-administrative arrangement such as exists in Unemployment Insurance. In view of the hazards of over-utilization and abuse, especially in home and office care, and the great administrative problems, it might be well to begin with a more limited program.

CHAPTER XVI

MEDICAL CARE PLANS CONSIDERED BY COMMISSION

At the outset, the members of the Commission on Medical Care ordered its researches and studies to be directed toward possible courses of action, to provide pertinent data upon which to base its decisions. Published material, the proffered and solicited suggestions of interested individuals and groups, and the researches of the study staff were summarized and distributed as soon as available to all members of the Commission in loose-leaf form, to serve as a basis for reference and for discussion at meetings. Over a period of slightly more than a year this material, known as Reference Material for Commission Members, amounted to nearly 700 pages. The plans which were considered are presented in chronological, evolutionary form.

More Adequate Care for Low-Income Non-Relief Groups

The Temporary Legislative Commission to Formulate a Long Range Health Program found that under the 1939 public medical care programs, care was generally available to persons receiving relief. However, they did not evaluate the adequacy of such care. They also found that "...medical care for the medically indigent group not on relief is far from satisfactory"^{1/}. In a study of 1,547 non-relief cases, it was found that only families with very low incomes (\$53.63 per month for families averaging 4.3 persons) were provided with medical or hospital care at public expense. In general, hospital care was provided more generously than other types of care, although practices varied considerably from welfare district to welfare district. Relatively little home medical care was furnished for the non-relief group upstate, and in New York City none was furnished.

The causes for this situation were thought to have lain in the lack of professional medical advice in determining medical need^{2/}, in a great variation in economic standards used in determining financial need, and (although not specifically mentioned) a reluctance on the part of welfare officials to assume any financial responsibility for families able to feed, clothe and house themselves.

^{1/} Medical Care in New York State, 1939, Legislative Document (1940)
No. 91.

^{2/} At the instigation of the Commission, in 1940 the phrase "The determination as to the medical care necessary for any person shall be made with the advice of a physician" was added to the Social Welfare Law, Section 184.

Proposed survey. It was proposed that the same field should be re-surveyed to determine whether improvement had been made, and to what extent. The proposed survey would have covered the following:

1. Repetition of the November 1939 study to determine income levels in the medically indigent group not on relief, for whom care was approved, and for whom care was denied by public welfare agencies.
2. Determination of income levels in the medically indigent group not on relief, for whom care was approved, and for whom care was denied by public agencies other than welfare.
3. Whether the amendment to the law cited^{2/} had been observed, and whether it had bettered the lot of this group.
4. Whether this group fared better where the determination of medical and financial need was made by a city or county agency with a medical director (full or part-time), than where need was determined by a town welfare officer, or city or county agency without a medical director.
5. Whether the rate of reimbursement to the welfare district might have any effect on liberalization of policy toward this group.
6. Whether medical care was more freely available to this group where provided by salaried physicians than on a fee-for-service basis, or vice-versa.
7. The reasons why the City of New York refused to provide home medical care for this group, pursuant to law.

Utilization of survey data. It was thought that upon completion of the study the Commission should consider:

1. Whether authorization of medical care should continue to be vested in the welfare agencies or should be transferred to another agency which would
 - a. Authorize necessary medical care without financial investigation for any recipient of public assistance.
 - b. Make its own financial investigation, using uniform standards, for any applicant for medical care who was not in receipt of public assistance.
2. Whether medical expenditures for non-relief as well as relief cases should be charged to welfare districts, and to what unit (town, city, county) the charge should be made.
3. Whether State reimbursement for medical care in home, office or clinic should not be greater than the 40 per cent granted for other forms of Home Relief.^{3/}
4. Whether State reimbursement for the costs of hospital care should be granted, and in what fashion and to what extent.

Although the study was initially approved by the Commission for completion, it was subsequently abandoned by the Commission at the request of the State Commissioner of Social Welfare.

Medical Insurance for Certain Groups of Relief Recipients

It is generally agreed that the insurance principle cannot easily be applied to Home Relief, Veteran Assistance, or "non-relief, needy" cases because frequently these cases become eligible for public assis-

^{3/} Rhode Island, for example, pays 70 per cent.

tance only because of sickness, sudden termination of employment, etc. Thus, aside from the physically and mentally disabled, the Home Relief and Veteran Assistance groups are shifting ones whose members come and go rapidly with changes in general and individual economic conditions, and which pose an extremely difficult problem for the actuary. In 1938 there were 298,743 Home Relief cases and in 1943 only 52,102 cases. On the other hand, there are three groups which are relatively stable and to which it might be possible to apply the insurance principle.

1. Old Age Assistance. This group is composed of needy persons 65 years of age or over. Once need has been established in such cases, there is relatively little change. In 1938 there were 111,143 cases and in 1943 there were 113,165 cases.
2. Assistance to the Blind. This group is composed of needy blind persons. Once need has been established, there is relatively little change. There were 2,654 cases in 1938 and 2,755 in 1943.
3. Aid to Dependent Children. This group is composed chiefly of fatherless children in homes where the mother or other relative needs financial assistance to preserve the family group until the children are 18 years of age. Ordinarily, this group is quite constant, but owing to a variety of conditions probably associated with the war, such as opportunities for mothers to work, cases have decreased from 34,768 in 1938 to 18,493 in 1943. Nevertheless, this is ordinarily a relatively stable group.

The relative stability of these three groups has been recognized to the extent that administrative regulations permit inclusion of an item for medical care in their monthly budgets. These groups, totaling 134,413 cases in 1943 and representing perhaps 158,000 persons, might be suitable for application of sickness insurance.

Application of the insurance principle. It has been suggested that the insurance principle be applied to the categorical relief group to:

1. Reduce administrative costs and red tape.
2. Secure a more uniform practice of providing medical care.
3. Increase the quantity and quality of medical care.
4. Reduce costs to localities and States by spreading the costs through insurance to take full opportunity of Federal funds. For example, under the present system Federal financial participation of 50 per cent in an Old Age Assistance Case does not continue beyond a total monthly budget of \$40. However, if the insurance principle were applied a premium for sickness insurance might be included in the budget of all. (An anticipated change in Federal regulations excluding medical expenditures from the "ceiling" of \$40 would invalidate this reason.)
5. Gain experience with the administration of a public sickness insurance system.

Comments. Careful study of this proposal indicated that little would be gained therefrom. The public would in any event pay from tax

funds the entire cost of medical care for these relief groups. Because the cost would be the same under either the present or an insurance system, there would be no spread of risk and thus no true application of the insurance principle. The group is numerically so small that the administrative experience gained would not be great, and administrative costs undoubtedly would be relatively high. Although red tape might be eliminated in the sense that medical care would not be administered under the rules of the public welfare department, the insuring agency would be faced with the necessity of imposing controls and regulations amounting to practically the same degree of red tape. Whether the quantity and quality of care would be improved is uncertain. The greatest advantage to be gained would be securing Federal funds not available under present rules; however, this advantage would disappear with the enactment of anticipated Federal legislation.

It therefore seemed that the purchase of medical and hospital insurance for categorical relief recipients would not be warranted at present. The possibility should, however, be reconsidered if and when a uniform comprehensive medical insurance plan becomes available throughout the State.

State Aid for Diagnostic and Health Centers in New York State

It has been frequently suggested that the State give financial aid to the operation of a system of diagnostic centers. Reference is usually made to the plan advanced by the late Herman M. Biggs, then State Commissioner of Health, as set forth in the Sage-Bill of 1920.^{4/}

Services provided by health centers. As described in the Sage Bill a health center would be more of an administrative than a physical unit. It would embrace general and special hospital facilities, diagnostic and therapeutic out-patient clinics for all types of illness, laboratory service of all types, and public health nursing service - in fact, all of the preventive, diagnostic and curative services. Services would be rendered by full or part-time salaried physicians in the employ of the center.

In addition, the State Department of Health would provide for periodic clinics and consultations by specialists at the center, to which private physicians might bring their patients.

^{4/} This constitutes a substantial part of A Health Plan for the State of New York - A Memorandum Prepared for the New York State Commission on Medical Care, L. H. Pink, December 11, 1945.

Eligibility and payment for services. Any person who wished to do so might turn to the health center for services, regardless of his ability to pay. However, a means test would be applied by the superintendent of the center, and patients would be required to pay in accordance with their ability, up to the full charge for service. The public welfare district would be liable for the costs that the patient could not pay.

In the clinics of the health center, all services would be rendered by salaried physicians and, presumably, most of the hospital care would be rendered by such physicians. However, a private physician who had been attending a patient prior to admission to a hospital of the health center would be allowed to continue to treat the individual as a private patient in the hospital, if the patient desired.

Administration. Health centers could be established by county or city legislative bodies. A board of managers of seven members, at least two of whom would be physicians, would exercise general administrative powers. The board would make rules and regulations as advised by the medical council, concerning medical matters, fees to be charged, and the salaries of employees. The board would appoint as its executive officer a superintendent, qualified as provided by the State Public Health Council. A medical council appointed by the board would be in charge of the medical and surgical affairs of the center. All of the facilities and activities of the center would be subject to the general supervision of the State Department of Health.

Financing. Funds for establishing and operating the center would be derived from fees charged patients, from general municipal taxes, and from State-aid. Since it would be the purpose of the Sage Bill to provide additional hospital and clinical facilities, grants would not be made for existing facilities, except special clinics for maternal and child welfare, tuberculosis and venereal disease. For new facilities and services approved by the State Commissioner of Health, State-aid of 50 per cent (within certain limits) would be granted for hospital and clinic construction, maintenance of laboratories, and free treatment given in the clinics. A fixed sum per day would be granted for each free hospital patient.

Comments. This bill had three major aims. The first was improvement of the quality of office and hospital practice through salaried group practice. The acceptance of the service would be voluntary, and payment would be made according to ability. The second aim was improvement of the quality of all types of medical care through making available the specialist consultations, hospital facilities, and diagnostic

services of all kinds. The third was to increase the quantity of care available by lowering costs through State-aid, and the employment of group methods of providing care.

The plan would not supplant the private practice of medicine, but would compete with it in the fields of office and hospital practice. The plan would not cover physicians' services in the home. Its greatest weakness would seem to be in that it was permissive rather than mandatory for cities and counties, which would probably result in an uneven acceptance throughout the State; further, even 50 per cent State-aid would probably be insufficient to enable the smaller and poorer localities to adopt it. In other respects, it seems to have been well conceived and worthy of serious consideration.

Medical Insurance Plans in General

Sensible of the wishes of the Governor and Legislature, the Commission sought a method which, not only immediately but in the future as well, would improve the quantity and quality of medical care without disturbing the general pattern of medical practice. Two chief methods were explored, of which the first was:

Extension of the existing pattern of governmental medicine, as exemplified by the programs of the State Departments of Social Welfare, Health, Mental Hygiene and Education. This method consists of increasing the amount of "poor man's medical care" by raising the level of financial eligibility, and of broadening existing programs or developing new programs of free medical care for specific diseases or services, e.g., free diagnosis and treatment of cancer, rheumatic fever, and orthopedic defects. The apparent advantage of this method is that it initially departs but slightly from the existing scheme of things. As it applies to many measures, chiefly preventive, it is a proper exercise of the police power of the State, and should be provided as a governmental service. However, for the great bulk of conditions requiring medical care it is, or may ultimately lead to, State medicine, to the rendition of services by physicians in the employ of the State, and to dependence of the people on the general wealth of the State rather than on their personal contributions.

Medical insurance financed by personal contributions constituted the second method explored. It consists of applying the "magic of averages" to medical costs, employing the insurance principle now practiced by the large number of New York State's residents enrolled in

hospitalization and/or medical insurance plans. The advantage of this method is that the practice of obtaining service from independent institutions and practitioners of medicine is unchanged. The individuality of the medical practitioner is unimpaired, free choice of physician is preserved, and people receive benefits for which they make direct, personal contributions.

A program having the general form of this second method, medical insurance, seemed to be the better suited to the wishes and needs of the people and the intent of the Governor and Legislature.

The present status of voluntary medical insurance. Commission studies revealed that approximately 23 per cent of the population of the State was covered by hospitalization insurance purchased from voluntary, non-profit (Blue Cross) organizations. The coverage by other types of hospitalization insurance amounted to no more than an additional 6 per cent.

About 3.6 per cent were found to be covered for some of the costs of physicians' services by non-profit, prepayment medical care or insurance plans (industrial, medical society, private group clinics, and consumer-sponsored), and about 3.3 per cent by private (commercial) insurance.

State assistance to voluntary plans. The possibility of assisting voluntary plans to extend their coverage was explored through various channels. Following a meeting with representatives of the major Blue Cross hospitalization insurance plans, the latter group organized a study committee which made recommendations to the Commission. Their suggestions for assistance that the State might give were of a rather minor nature. They concluded (without approving the principle) that the objective of covering essentially all of the people of the State at an early date would be achieved only by adoption of legislation compelling the purchase of hospitalization insurance.

A meeting with the Medical Planning Committee of the Medical Society of the State of New York produced the opinion that any obligation to the public would have been discharged when insurance against the costs of major illness was made available (as it is, or soon will be) throughout the State. They did not recognize the inability of many self-supporting persons to pay the premiums for this type of insurance. They advised the Commission to limit its interest to the care of the indigent and near-indigent, and to do nothing toward encouraging, subsidizing, or otherwise developing voluntary or other insurance for any group other

than the indigent. Representatives of the non-profit medical insurance plans also thought that there was little the State could or should do, except to make it possible for municipalities to make payroll deductions and contribute toward premiums for their employees who enrolled in voluntary plans.

Proposals have been made, however, by national and local representatives of Blue Cross plans, members of the United States Senate, and other groups, for governmental subsidy of existing voluntary medical and hospitalization insurance organizations. Such proposals were not considered by the Commission to be feasible because, first, they would entail the use of public moneys for the benefit of a limited group selected not on the basis of need but on the basis of having voluntarily paid a premium to an insurance organization, and, second, the New York State Constitution expressly prohibits the loan or gift of State funds to any private individual or corporation.

A "voluntary" health insurance bill⁵ introduced in Massachusetts proposed that if 75 per cent of the employees of a firm recorded their wish for health insurance, the employer would be obliged to furnish it and pay one-half of the cost. In addition to the fact that such a plan would be extremely difficult to administer, it could not properly be termed voluntary because it would be compulsory for the employer.

Among the other obstacles to increasing medical and hospitalization insurance coverage on a voluntary basis are: the impossibility of grading premiums in accordance with ability to pay;^{5/} the actuarial dangers of enrolling members at reasonably low premiums except in groups based upon employment, which eliminates many self-employed, casual, agricultural and other workers; the medical opposition to combining hospitalization and medical insurance organizations; and the rather limited physicians' services offered as benefits.

Upon analyzing the proposals made by persons interested in greatly extending coverage by voluntary insurance plans it was found that they entailed:

compelling the payment of taxes to be used as a direct subsidy to the voluntary insurance plans, or

compelling the payment of taxes to be used as a direct subsidy to the low-income person or family wishing to enroll in a voluntary insurance plan, and for automatic enrollment of the indigent, or compelling the employer to pay about one-half of the premium for persons wishing to enroll in a voluntary insurance plan.

^{5/} This was to have been attempted by the Health Insurance Plan of Greater New York, but has been abandoned.

There was no escape from the conclusion that voluntary insurance could not be extended to cover all of the population without compelling those of above-average income to assist those of below-average income.

Compulsory medical insurance. Since the degree of compulsion disclosed by the above analysis seemed to be generally acceptable, a means was sought of making it possible for everyone to obtain benefits from a voluntary insurance plan through a form of indirect financial assistance to persons and families of below-average income. This could be accomplished through the State constitutional authority to compel persons to contribute in accordance with ability to pay. The element of compulsion could be limited to the contribution, and the contributor would be free to receive service through the existing voluntary plans. In this fashion, the objective of enrolling the indigent, the near-indigent and the unacceptable medical risks by means of a governmental subsidy would be realized.

The term "compulsory" as applied to medical insurance may have a variety of meanings. In its least comprehensive form it may mean only, as in the case of the Massachusetts bill previously cited, that the employer is compelled to pay one-half of the cost of insurance voluntarily purchased by his employees. In its most comprehensive form it may mean complete governmental control, from contribution to the actual provision and complete control of every phase of medical service. For the purposes of the Commission it has meant only that everyone would be compelled to contribute in accordance with his ability to pay. The widest possible latitude would be afforded for voluntary selection of the administrative agency and the physician, dentist, hospital, etc.

Because there is an undeniably strong movement throughout the nation for compulsory medical insurance, existing and proposed plans and the public attitude were studied carefully.

The public attitude toward compulsory medical insurance. From various surveys, including the one conducted by the Commission (see Chairman's supplementary report, and PART 3 of this report), it appears that a majority of the people want some kind of insurance covering hospital care and medical care and that a majority would support a compulsory government insurance plan. The people of New York State expressed their attitude toward medical insurance in 1938 by voting by a large majority that "nothing....in this constitution contained shall prevent the legislature from providing for....the protection by insurance or otherwise, against

the hazards of....sickness...."^{6/}

Commission studies. To permit study of the basic principles involved in compulsory insurance, the Commission ordered the preparation of a basic plan for hospital care which would embody the principles of (1) coverage of all residents of the State, (2) compulsory contributions, and (3) provision of service by the State and by voluntary and private insurance organizations, the plan to be so framed that other features such as medical care in the hospital or in the physician's office could be added with little or no revision of the basic plan. Committees were appointed to study the various features of this plan, it being understood that they would be free to consult authorities outside of the Commission membership. The committees were as follows:

Nursing. Miss Sheahan, Chairman, Dr. L. Brown, Miss Gelinas, Miss Hall

Finance. Mr. Winston, Chairman, Senator Hammer, Assemblyman Mailler

Usage. Assemblyman Mailler, Chairman, Msgr. Bingham, Dr. L. Brown, Dr. MacCurdy

Administration. Dr. MacKenzie, Chairman, Dr. Godfrey, Mr. Lansdale

Benefits and Coverage. Dr. Weiskotten, Chairman, Dr. Godfrey, Senator Joseph, Dr. MacCurdy

Public Opinion Survey. Dr. Levy, Chairman, Assemblyman Farbstain, Mr. Lansdale, Mr. Winston

From the reports of these committees and discussions by the Commission as a whole, a set of guiding principles for any medical insurance program were evolved and adopted by the Commission.

Guiding Principles for a Medical Insurance Program

1. All persons should be covered. Selective Service, school, pre-employment and similar medical examinations and surveys reveal a large number of our people to be suffering from remediable or preventable physical and behavioral defects. These defects are more common in persons for whom care is not easily available because of their geographic location, type of employment or economic status. This is a matter of public concern because disability in adults impairs productive capacity and leads to financial dependence on the community, and because indifference, poverty or improvidence of parents may deprive children of

^{6/} Constitution of the State of New York, Article VII.

their rightful heritage of health.

To overcome these obstacles to good care for all, persons of all groups and classes should be entitled to the benefits of a prepaid medical care plan. Thus, there should be included the regular wage earners, the self-employed and those irregularly employed, the indigent, and the dependents of these persons, without any means test or income limit.

2. Complete benefits should be available to all. Persons temporarily or permanently unable to contribute more than the fixed amount for insurance should be able to obtain complete medical service without additional payment. Because there would be no means test, such complete service would be available to persons at any income level. On the other hand, in the interest of preserving freedom of choice and avoiding regimentation, persons willing and able to pay more to indulge personal preferences and a desire for more costly service should be permitted to do so. The plan should thus provide:

a. complete service without additional payment, for those who wish it, regardless of their financial status; and

b. an allowance approximating the actual cost of basic service to be paid by the insuring agency to the person or agency providing service, against bills contracted by those desiring to pay more.

Exclusions. The care of tuberculosis and mental disease, the community aspects of detection and control of communicable disease, and medical service for school children, all of which require the application of mass methods and which are traditionally a responsibility of government, should be provided as public measures and should be excluded from the insurance features of the plan. The care of inmates of correctional and custodial institutions should also be excluded. All other medical services rendered directly to individuals, except in Workmen's Compensation and other forms of private liability, should be included in the program.

3. Compulsion should be limited to the contributory features of the plan. Compulsory contribution, a measure which is expressly provided for in the Constitution of New York State, is the only means of making medical care available to all. However, to preserve the traditional American principles of individual initiative and free enterprise, compulsion should be restricted to the minimum degree necessary to accomplish this objective.

Limiting compulsion to the feature that everyone contribute financially to a medical care system would avoid regimentation and would classify

this measure with other accepted compulsory contributions for the public welfare, such as education, defense, highways, police and fire protection. The greatest possible choice should be retained with respect to type of service, the person or agency rendering the service, and the right to refuse service or to purchase extra service.

4. Free choice of service should be allowed. Preservation of the integrity and freedom of action of the individuals and agencies providing medical care is of great importance in maintaining quality of service. Any qualified institution or professional person should be free to serve or to decline to act under the plan. Those participating should be free to serve in either a group or individual capacity. Individual practitioners should have the right to decline or accept any individual patient. A patient other than a hospital patient should have free choice of physician or group of physicians. As a hospital patient he should have free choice of physician, subject, however, to the rules of the hospital.

To preserve freedom of choice by the patient, any person should be free to elect at any time either

a. complete service, without additional payment, which service would consist of basic hospital care, or medical service by a group organized for this purpose; or

b. the purchase of more expensive accommodations or personal service, the patient to pay the difference between the amount charged and a basic allowance fixed by the insuring agency.

5. Contributions should be in accordance with ability to pay.

Everyone would benefit from sickness insurance and everyone should contribute according to his ability. That everyone might realize he was paying to the extent of his ability for service received, contributions should be clearly designated as for medical care. A material part of the cost should be met from a premium to be paid by everyone who has the means, based roughly upon what people now pay for care; in addition, a part of the cost should be borne by a tax on income, with an upper limit. No contribution should be required of employers. Localities should contribute for persons receiving public assistance. Funds required in addition to those realized from contributions should be derived from general tax revenues.

6. Payment should be adequate to insure good medical care. The object of a medical care program is to protect and promote the health of the people. The people do not now receive all of the care that is needed because of inability to pay, and because of unawareness of need. Because

expenditures at the current level will not pay for all of the care that is or will be necessary, revenues and payments should be adequate to insure good medical care by providing all that is needed. The remuneration of individuals rendering service should be in conformity with the high standards of care expected of them, and in accordance with their investment of time and money in training.

7. Administration and direction should be under professional supervision. The authority to practice in the medical and allied professions, and to establish and maintain hospitals, is granted by the people. The basic control of a medical care program is likewise vested in the people and their wishes should be consulted through their representatives in the Legislature. The professional aspects of a program require expert knowledge and should be directed by professional persons of proven competence. Administrative policies should be formulated with the advice of regularly constituted boards representing the interests involved - professional for professional matters, public for public matters, and a suitable combination for matters involving both.

In providing service, the integrity and freedom of action of individuals and agencies should be preserved. Disputes should be settled and abuses controlled by the administrator with the advice of appropriate professional boards. Administration should be decentralized on a regional basis in order that local variations might be taken into account and opportunity be afforded for personal working relations between the administrator and persons or agencies providing service. Appropriate local advisory boards should function in each region.

8. Care of good quality should be a major aim. To justify its creation and existence a medical program should provide care of good quality. The organized medical profession states that its opposition to any compulsory feature of a medical care program is based upon the belief that the quality of care would inevitably suffer. To guard against this danger a program should leave the primary responsibility for quality where it now rests, i.e., with the medical schools, the organized medical and related professions; and the voluntary agencies. Public aid should be rendered these organizations in discharging this responsibility by guaranteeing their freedom of action and, materially, by assisting them in the development and maintenance of facilities and opportunities for research and continuing postgraduate education.

9. Facilities and services should be located in accordance with determined needs. The increased ability to purchase medical care which would be gained under the insurance features of a medical care program would not of itself be sufficient to guarantee the geographic distribution of facilities and services in accordance with needs. Physicians and other personnel of high quality would not be attracted to communities where the facilities and services necessary for good, modern medical practice were not readily accessible. Also, some communities would not have the financial resources for necessary capital expenditures. In order that there would be distribution according to need, the medical care program should include provision for loans or grants; under the State constitution these may be made only to local governments. The establishment or augmentation of facilities and services should be made in accordance with a plan for integrated regional development.

10. Continuous improvement should be sought through research. Research in medical sciences would continue to exist independently. In the medical care program, research for the purpose of improving and simplifying administrative methods, and for determining and meeting medical needs should be a continuous and important activity.

11. Education of the public should be carried on. To realize the potential benefits in a medical care program the public should be taught to use it properly. Medical care should be sought when and to the extent needed, and should not be sought when unnecessary. Emphasis should be placed on the use of medical benefits for prevention of disease and disability. Education of the public in the purposes and proper use of the services available should be an integral part of the program.

12. Prevention should be emphasized. The occurrence of some diseases can be prevented; there are others which cannot be prevented but in which permanent or prolonged disability may be prevented by early detection and prompt treatment. Departments of health and related agencies should vigorously pursue such preventive activities as environmental sanitation, industrial hygiene, accident prevention, the control of communicable disease, and the application of mass methods for early case finding. The medical care agency should in no way restrict the public health agency in the latter's duty of determining needs and devising methods by which such needs should be met. It should be the function of the medical care plan to supplement and implement the broad public health program by making it possible for individuals to obtain the medical care necessary to accomplish the objective of prevention.

Summary of Features of Plans Studied

Although it would be ideal to provide complete medical, dental and hospital service in a program, a majority of Commission members believed that certain financial and administrative considerations would make it impossible to attain this idea at present. Accordingly, a great variety of plans were prepared, several of which are summarized in this section. The cost of other plans may be derived from the detailed figures given in Chapter XX. The broad features of coverage, benefits and their costs, administration, and revenues are dealt with in subsequent chapters.

In examining the summaries it should be kept in mind that although the cost figures are as accurate as it is possible to make them, they are not necessarily final. For example, hospital service costs were based upon 1942 figures and would probably have to be revised upward for a plan inaugurated in, say, 1947. The cost of physicians' services were based upon the New York State Workmen's Compensation Fee Schedule, and a different fee schedule might result in somewhat different figures. In all of the plans, coverage would be provided for all residents of the State within the specified age groups. Workmen's Compensation cases, and tuberculous and mental cases after diagnosis would be excluded. Individual medical services would be paid for chiefly on a fee-for-service basis. Hospitals would be paid on a cost basis for basic service, i.e., the equivalent of ward accommodations, plus all necessary nursing, laboratory, x-ray and related services. To the total cost of benefits there has been added about 10 per cent as operational or administrative cost.

There would be no interference by the State in the voluntary selection by patients of physicians, dentists, hospitals, etc.

The contributions that would be required are only illustrative. They have been derived by dividing the estimated cost of the plan by the estimated personal income that would be subject to taxation in a normal postwar year. As stated in Chapter XXII, about \$12,000 million would be reached by a tax applying to the first \$5,000 of income, and about \$14,000 million by a tax on all personal income.

Table 1. Summary of Benefits Provided, Total Annual Costs, Average Per Capita Cost, and Illustrative Tax Rates and Contributions Under Seven Different Plans for Medical Care or Insurance

Benefits	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6	Plan 7
Total annual cost, in millions of dollars							
Physician, all care - home, office and hospital	258.0	c/	c/	c/	-	c/	d/
Physician, home & office only	a/	-	c/	c/	-	c/	177.0
Physician, surgical & obstetri- cal care - home, office and hospital	a/	72.0	c/	72.0	-	c/	d/
Eye refractions	13.0	c/	c/	c/	-	c/	13.0
Physician, all care under 8 years - home, office and hospital	a/	34.7	34.7	34.7	-	34.7	a/
Physician, well-child care, under 8 years	10.0	10.0	10.0	10.0	-	10.0	10.0
Diagnostic x-ray & laboratory							
Hospital patients only	b/	b/	b/	18.5	b/	b/	-
Home and office patients	a/	16.0	16.0	16.0	-	1.0	a/
Dental service, under 8 years	9.0	9.0	9.0	9.0	-	9.0	-
Hospital service, complete	107.6	107.6	107.6	-	107.6	16.5	-
Visiting nurse service	2.4	2.4	2.4	2.4	2.4	0.5	-
Cost of benefits	400.0	251.7	179.7	162.6	110.0	71.7	200.0
Administration	40.0	25.3	17.3	16.1	10.0	7.5	20.0
Total	440.0	277.0	197.0	178.7	120.0	79.2	220.0
Average per capita cost (dollars) e/							
	32.00	20.15	14.33	13.02	7.73	57.45	16.00
Illustrative rate and amount of tax applying only to first \$5,000 of income							
Tax rate, per cent	3.67	2.31	1.64	1.49	1.0	0.66	1.83
Amount of tax, if income of							
\$ 500	18.35	11.55	8.20	7.45	5.00	f/	3.17
1,000	36.70	23.10	16.40	14.90	10.00		18.33
2,000	73.40	46.20	32.80	29.80	20.00		36.66
3,000	110.10	69.30	49.20	44.70	30.00		55.00
4,000	146.80	92.40	65.60	59.60	40.00		73.33
5,000	183.50	115.50	82.00	74.50	50.00		91.67
10,000	183.50	115.50	82.00	74.50	50.00		183.33
Illustrative rate and amount of tax applying to all income							
Tax rate, per cent	3.14	1.93	1.41	1.28	0.86	0.56	1.57
Amount of tax, if income of							
\$ 500	15.70	9.90	7.05	6.40	4.30	f/	7.87
1,000	31.40	19.80	14.10	12.80	8.60		15.74
2,000	62.80	39.60	28.20	25.60	17.20		31.48
3,000	94.20	59.40	42.30	38.40	25.80		47.22
4,000	125.60	79.20	56.40	51.20	34.40		62.97
5,000	157.00	99.00	70.50	64.00	43.00		78.71
10,000	314.00	198.00	141.00	128.00	86.00		157.41

a/ Included in "Physician, all care - home, office and hospital."

b/ Included in "Hospital service, complete."

c/ Included for children in "Physician, all care under 8 years - home, office and hospital."

d/ Home and office service included in "Physician, home and office only."

e/ Under Plan 6, per capita cost is for children under 8 years of age.

f/ Not computed, because tax for Plan 6 would probably not be on straight income basis.

The plans summarized in Table 1 may be described briefly as follows:

- Plan 1: Comprehensive. This plan would provide all medical, hospital, and diagnostic service, visiting nurse service, and complete preventive and dental service for children under 8 years of age. It would cover practically all medical needs at an average per capita cost of \$32.00, and would require a tax of from 3.14 to 3.57 per cent of personal income.
- Plan 2: Surgical-obstetrical-hospital-diagnostic-child care. This plan would correspond roughly to the combined service purchasable from most non-profit hospitalization and medical care insurance plans. However, in addition to hospital service and surgical and obstetrical services rendered by physicians in the home, office or hospital, it would add the important features of complete x-ray and laboratory diagnostic service for persons of all ages, complete medical and dental care for children under 8 years of age, and visiting nurse service.
- It would cover the major costs of illness for adults, and all care for children, at an average per capita cost of \$20.15, and would require a tax of from 1.98 to 2.31 per cent of personal income.
- Plan 3: Hospital-diagnostic-child care. This plan resembles Plan 2, except that it would not provide physicians' services for obstetrical cases or for surgical cases in persons over 8 years of age. It would cover a major item of medical costs for adults and all care for children at an average per capita cost of \$14.33, and would require a tax of from 1.41 to 1.64 per cent of personal income.
- Plan 4: Surgical-obstetrical-diagnostic-child care. This plan resembles Plan 2, except that it would not provide hospital service other than for x-ray and laboratory diagnosis. As in Plan 3, a major item of medical costs for adults and all care for children would be covered. The average per capita cost of \$13.02 would require a tax of from 1.28 to 1.49 per cent of personal income.
- Plan 5: Hospital. This plan would provide only hospital and visiting nurse service. It would cover a major item of medical cost, extending to everyone basic benefits somewhat greater than are provided by the Blue Cross plans. The average per capita cost of \$8.73 would require a tax of only 0.86 to 1.0 per cent of personal income.
- Plan 6: Child care. This plan would provide complete medical, dental, hospital and preventive services for children under 8 years of age. It would provide a sound experimental approach to universal comprehensive medical insurance.
- Plan 7: Home and office care. This plan would provide all home and office care by physicians, emphasize prevention and early diagnosis, but would also include curative services. It would cover an important sector of medical need at an average per capita cost of \$16.00, and would require a tax of from 1.57 to 1.83 per cent of personal income.

CHAPTER XVII

CONFERENCES ON MEDICAL INSURANCE WITH REPRESENTATIVE GROUPS

Plans Discussed

In August 1945 the Commission undertook to consult groups representative of agriculture, labor, industry, commerce, medicine, dentistry, nursing, hospitals, voluntary (non-profit) and private insurance agencies writing medical and hospitalization insurance. To serve as a basis for discussion, conferees were provided with a 47-page booklet entitled Alternative Plans for Medical Insurance in New York State. The booklet briefly reviewed the studies and deliberations of the Commission and set forth three alternative plans which the Commission had adopted for the purposes of these discussions. The three plans are presented in Table 1 as they appeared in the booklet. A detailed description of the features of the plans was also presented, together with a description of the methods employed in arriving at the cost and revenue figures. The features of all three plans may be summarized as follows:

1. General objective. The extension of coverage similar to that now afforded by voluntary medical insurance plans, to all persons through a form of indirect financial assistance to persons and families of below-average income. This would be effected by use of the State constitutional authority to compel persons to contribute to such a plan in accordance with their ability to pay. The element of compulsion would be limited, however, to the contributory features. The effect of the plan would be to make medical benefits available to those who otherwise would not receive them because of lack of means, or because of indifference.
2. Coverage. Every person who had resided in the State for a year or more would be covered, including the indigent.
3. Benefits. (As designated in Table 1).
4. Provision of benefits. Beneficiaries could freely exercise the right to select their physicians, dentists, hospitals, etc., subject only to the consent of such physicians, dentists or hospitals.

General medical and dental service could be obtained, without prior authorization, from any licensed practitioner or approved medical or dental group. Specialist services could be obtained, upon recommendation of the attending physician and without prior authorization, from any physician qualified by an American Medical Specialty Board or by the State Administrative Agency.

Table 1. Summary of Features of Three Plans Discussed

Features	Plan 1	Plan 2	Plan 3
Coverage	All residents	All residents	All residents
Benefits	Physician - all services in hospital <u>a/</u> Home nursing X-ray & laboratory diagnosis Hospital patients Non-hospital patients Dental care, children 3-8	Physician - all services in hospital Home nursing X-ray & laboratory diagnosis Hospital patients Non-hospital patients Dental care, children 3-8 Hospital service <u>a/</u>	Home nursing X-ray & laboratory diagnosis Hospital patients Non-hospital patients Dental care, children 3-8 Hospital service <u>a/</u>
Benefits provided through	Free choice of practitioner & hospital	Free choice of practitioner & hospital	Free choice of practitioner & hospital
Payment	Service and indemnity <u>b/</u>	Service and indemnity <u>b/</u>	Service and indemnity <u>b/</u>
Costs in millions of dollars	Physician \$93.0 Home nursing 2.4 X-ray & laboratory diagnosis Hospital patients 18.5 Non-hospital patients 16.0 Dentists 9.0 Administration 14.0 Reserve 7.1 Total 160.0	Physician \$93.0 Home nursing 2.4 X-ray & laboratory diagnosis Hospital patients (included in hospital) Non-hospital patients 16.0 Dentists 9.0 Hospital service 107.6 Administration 23.0 Reserve 11.5 Total 262.5	Home nursing \$ 2.4 X-ray & laboratory diagnosis Hospital patients (included in hospital service) Non-hospital patients 16.0 Dentists 9.0 Hospital service 107.6 Administration 13.5 Reserve 7.0 Total 155.5
Revenues in millions of dollars	Premium @ \$6.00 55.8 Income tax 100.6 Local @ \$0.25 3.4 Federal 0.2 Total 160.0	Premium @ \$7.50 69.75 Income tax 161.55 Local @ \$2.25 30.0 Federal 1.2 Total 262.5	Premium @ \$6.00 55.8 Income tax 71.7 Local @ \$2.00 27.0 Federal 1.2 Total 155.5

a/ Includes anesthesia.

b/ Service for home nursing, x-ray and laboratory diagnostic service, basic hospital service, anesthesia and dental care. Combined service and indemnity for physicians' services.

The governing board, or any group of physicians or dentists who constituted the staff of a non-profit or public hospital or dispensary, could incorporate as an approved medical or dental group under the plan.

Any qualified individual, laboratory or hospital could provide x-ray and laboratory diagnostic service, without prior authorization, upon recommendation of the attending physician. Any non-profit or public nursing agency could contract to provide visiting nurse service, without prior authorization, upon recommendation of the attending physician.

Any hospital would be free to provide service, without prior authorization, upon recommendation of a physician.

5. Payment for service. Medical and dental services would be paid for at rates in a fee schedule established by the State administrative agency in consultation with the professions. Physicians, dentists and groups might make charges in addition to the fees allowed under the plan but, as in voluntary plans, payments to such persons and groups might be pro-rated if necessary to balance income and expenditures.

However, groups or individuals might agree to provide service at fees not in excess of the schedule, in which event they would be guaranteed the full fee. These obligations would be settled before payment was made to individuals and groups who did not agree to this practice.

X-ray, laboratory and home nursing services would be paid for at rates contracted with the administrative agency. Extra charges would not be sanctioned.

Hospitals would be paid on a per-diem cost basis. Extra charges would be sanctioned only for more costly accommodations (private room, etc.)

6. Contributions.

- a. Individual premiums. Each resident of the State 18 years of age or older (not in receipt of public assistance) would be required to pay an individual premium of nominal amount, perhaps \$5.00 or \$7.50. This would serve the purpose of emphasizing to each person that he was making direct payment for benefits available to him; it would ensure some income from the casually employed and others who might otherwise escape

taxation, and would also serve as a registration device.

- b. Tax on income. Residents, and others who derived income from within the State, would be required to pay a flat-rate tax on the first \$5,000 of gross earnings and other cash income, less expenses incurred in the production of such income. No exemption would be allowed for dependents since they would benefit under the plan and no charge would be made for them. Non-residents would be taxed only on earnings in the State, and would be permitted an exemption of \$500. The greater part of the tax would be collected by withholding from wages and salaries.

The amount of the individual premium or premiums paid by a family would be credited against the tax payable on income.

- c. Public welfare district contributions. In return for being relieved of present expenditures for the indigent, local public welfare districts would be required to contribute a reasonable sum on the basis of the general population of such district. Contributions would be based upon general population rather than relief load, to permit tax stability in periods of economic depression.
- d. Federal moneys. Federal moneys available to the State for medical care under child welfare, vocational rehabilitation, old age assistance programs, etc. could be received by the plan for benefits furnished by it.

- 7. Deductions. There could be deducted from the total tax liability of an individual or family, payments made to a non-official insurance agency for medical and/or hospitalization insurance, and also the value of pre-paid medical services financed by an employer, union, etc. The amount deductible would be fixed by the State administrative agency as the amount equivalent to the cost of benefits specified in the plan.^{1/} This device would permit

^{1/} For example, a man with wife and two children, with income of \$4,000 per year might be liable to a total tax of \$50. This family might pay \$42 per year to a private plan for benefits equivalent to those furnished under the State plan, and the State-fixed allowance might be \$40, which would leave \$10 as the net tax liability.

On the other hand, a family with \$2,500 income might have a total tax liability of only \$32. This family might choose to pay \$40 to a private plan, which would cancel the tax liability.

an individual or family to join or continue in a non-official plan if desired, and to continue to benefit from contributions made on their behalf by an employer.

8. Administration.

- a. State. The formulation of policies and the enactment of a medical insurance code to supplement the basic law would be entrusted to a State agency representing the public and the participating professions. Appropriate professional or technical committees advisory to the agency and director would be authorized. The administrative and executive powers would be entrusted to a director appointed by the Governor.
- b. Local. Administration would be decentralized, and the greatest degree of local autonomy possible granted through utilization of local non-official agencies and through local committees advisory to local State administrative agencies.

Any individual or family could enroll voluntarily in a non-official plan, premium payments being credited against tax liability as described in the section on deductions. These non-official insurance agencies would come under the supervisory and rate-fixing powers of the State administrative agency, as they are now under the State Departments of Insurance and Social Welfare.

If it seemed desirable to do so in a given area, the State agency could enroll in a non-official agency persons who had not voluntarily enrolled in such an agency. The State agency would administer the plan in other areas.

Conduct of Conferences

The following letter was sent to the representative groups:

The Commission on Medical Care is desirous of obtaining the advice and counsel of your organization on a medical plan for New York State, and requests that you name a committee of your members to meet with representatives of the Commission for a discussion of this subject. The meeting will be held....

As you know, the Commission on Medical Care was created by the Legislature at the request of the Governor to formulate a medical care program for persons of all groups and classes. After ten months of thorough study of medical care, we believe ourselves to be well-informed as to the resources of the State, its needs, and practicable measures by which such needs might be met. We are now at a point where we possess the data to deal in specific terms rather than generalities, and where we seek the helpful opinion of such

interests as medicine, dentistry, nursing, hospitals, labor, industry, agriculture and the general public.

As a basis for our conference, medical care plans have been prepared which will be sent to your representatives at least one week in advance of the meeting. In studying these plans, please bear in mind that they have been approved by the Commission only for submission to interested groups for discussion. We expect to amend and revise the plans as we proceed with our conferences and, as a consequence, they are not to be made public by anyone until the suggestions and attitudes of the interested groups have been determined and appropriate revisions made, consistent with the broad objectives of the Commission.

We consider, and want you to feel, that you are actively participating in the formulation of the plan which will ultimately be recommended for adoption by the Legislature. If conditions warrant, conferences in addition to this one will be held with your group for further clarification and exchange of ideas.

The members of the Commission with whom you are asked to meet are....

It is asked that you appoint not less than three nor more than six persons to attend the conference, persons who are in a position to speak authoritatively even though they may be unable to make definite commitments on your behalf.

At each session, the presiding Commission member indicated the desire of the Commission for advice and guidance. It was stressed that the meetings were informal and that it was not the intent of the Commission to commit any group or individual. It was mentioned, also, that while the Commission's proposals served as a basis for discussion, they did not limit the scope of the discussions. The conferees were asked to keep in mind that although the legislation establishing the Commission employed the term "medically needy persons," the Governor had interpreted the law to include the needs of all groups and classes and had directed the Commission to study and plan accordingly. It was stated that the Commission had a deep interest in the adequacy of facilities for rendering the services included in its proposals, but that the actual study of medical facilities and recommendations for their supplementation was the assignment of the Health Preparedness Commission, and the Joint Hospital Advisory Committee of the State Post-war Planning Commission, the Commission on Medical Care having been instructed by law to avoid duplications in this field. All groups and individuals were requested to submit a letter or memorandum covering their views as expressed at the conferences, and any further comments or proposals they wished to make.

Notes on the conferences. Brief notes taken from the minutes of the

conferences and from letters and memoranda submitted by the persons and groups consulted, are presented below. With one exception, the groups felt that the discussions should concern only the most comprehensive of the plans, i.e., Plan 2, covering hospital service, visiting nurse service, x-ray and laboratory diagnostic service, all physicians' services for hospitalized cases, and complete dental service for children under 8 years of age (the last being susceptible of progressive increase to cover older children).

New York State Conference of Hospital Service Plans

Representatives of hospital service plans:

J. Campbell Butler, President of the New York State Conference of Hospital Service Plans, Group Hospital Service, Inc. of Syracuse; Robert E. Johnson, Chautauqua Region Hospital Service Plan; Sherman Meech, Rochester Hospital Service Plan; Carl M. Metzger, Hospital Service Corp. of Western New York; Louis H. Pink, Associated Hospital Service of New York; C. Rufus Rorem, American Hospital Association, Hospital Service Plan Commission; Harold C. Stephenson, Hospital Plan, Inc. of Utica; Allen Thompson, Associated Hospital Service of New York.

Representatives of the Commission:

Dr. Basil C. MacLean, presiding; Dr. Paul A. Lembcke, Director of Study. Mr. Leon Fischel representing Assemblyman Mailler. Not present: Dr. Godfrey, Dr. MacCurdy, Mr. Winston, Miss Sheahan.

This group did not submit a memorandum. They stated that they believed that the decision as to whether there should be a compulsory plan should be made by the people of the State, and for this reason would make no recommendation on the subject. Mr. Pink seemed to express the view of the majority in characterizing himself as loath to accept compulsion unless necessary. If compulsory insurance were desired by the public, he said, the State should permit the individual to obtain his insurance from the State, or from any private agency meeting minimum standards established by the State as to rates, benefits, administration, etc. The Blue Cross and other cooperative plans could compete with a State insurance plan on this basis. In purchasing insurance from private agencies, the individual should have the option of making extra payment for additional benefits (e.g., semi-private accommodations).

Although administrative difficulties might be experienced in providing out-of-hospital benefits, it was considered advisable that out-of-hospital minor surgery be provided so that patients would not be hospitalized unnecessarily in order to obtain minor surgical benefits.

New York State Federation of Labor

Representatives of the Federation:

Frederick F. Umhey, Executive Secretary, International Ladies Garment Workers Union; Commissioner E. W. Edwards, State Commission Against Discrimination, Vice-President of N.Y. State Federation of Labor; Harold C. Hanover, Secretary-Treasurer, N.Y. State Federation of Labor; William Galvin, President, Biscuit and Cracker Workers Local No. 405.

Representatives of the Commission:

Dr. Basil C. MacLean, presiding; Dr. Harold R. Brown; Assemblyman Leonard Farbstein; Senator Frederic Hammer; Garrard Winston; Dr. Paul A. Lembcke, Director of Study; Mr. Leon Fischel representing Assemblyman Mailler. Not present: Senator Joseph.

The representatives of the Federation of Labor felt that there was "a desire and an absolute need from an economic and social standpoint" for compulsory medical insurance. The principle of coverage of the entire population was endorsed, but they felt that benefits should preferably be more comprehensive, including home care. The belief was also expressed that New York State employers could contribute toward the costs of a medical insurance plan without being placed at a serious competitive disadvantage with out-of-State employers.

Objections were raised to the indemnity provisions of the plan, it being felt that because the public was compelled to contribute financially, the medical profession should be compelled to accept the scheduled fee as payment in full, except in cases where there were complications, etc., calling for a greater amount of work than was covered in the fee schedule. The option of the physician to charge fees in excess of the schedule would be unfair to the low income person.

It was later reported that:

....we are not favorably disposed to the Medical Care Plan as we understand it, mainly because of the high employee contribution. We are also not in favor of the charges shown for physicians coupled with the amounts allowed over and above fixed fees.

International Ladies Garment Workers Union

Representatives of the ILGWU:

Dr. Leo Price, Union Health Center; Pauline Newman, Union Health Center; Charles S. Zimmerman, Dressmakers' Union, Local 22; Adolph Held; Frederick F. Umhey, Executive Secretary, ILGWU.

Representatives of the Commission:

Dr. Basil C. MacLean, presiding; Dr. Harold R. Brown; Assemblyman Leonard Farbstein; Mr. Garrard Winston; Dr. Paul A. Lembcke, Director of Study; Mr. Leon Fischel representing Assemblyman Mailler. Not present: Senator Joseph.

It was felt that a compulsory plan was necessary to the solution of the medical care problem. The failure of the Commission plans to provide comprehensive benefits was deplored. In a discussion of the Union Health Center plan, the hazard of excessive use of out-of-hospital service, whether provided on a fee-for-service, salary or other basis was recognized, but it was felt that at least a limited amount of out-of-hospital care - possibly 4 office and 2 home visits per year - should be added to the Commission's Plan 2.

Although the employer may fear that the cost of contributing to a medical insurance plan would be detrimental to him, experience has shown that in social legislation New York State sets the standard and gradually the rest of the country comes up to it, removing any initial disadvantage that may exist. Many New York State employers in highly competitive fields (clothing, hosiery, electrical supplies, millinery, etc.) now contribute toward health insurance for their employees. The opinion was expressed that if an employer tax is imposed, an employee and a self-employed person should be taxed equally, and the tax on the employer should be independently levied. This would be preferable to a system whereby the employer and employee would each be taxed at, say, $1\frac{1}{2}$ per cent, and the self-employed person at 3 per cent.

It was suggested that it might be desirable to continue private medical plans such as the industrial, union and Blue Cross organizations, to permit adaptability to local needs and conditions.

A formal report did not reach the Commission, but a letter from the Director of the Research Department stated that the ILGWU attitude corresponded to that of the New York State Federation of Labor. After comment upon President Truman's health message to Congress, it was stated that:

....one must be impressed with the disabilities of State action in matters of social legislation as compared with the superior decision and resources of the Federal government. If the State finds itself superseded, it is because it is timorous and behind-hand. I wonder whether your Commission will not now get itself up to proposing something more thoroughgoing and sufficient than it has heretofore considered.

Medical Society of the State of New York

Representatives of the Medical Society:

Dr. Thomas McGoldrick, Brooklyn; Dr. H. H. Bauckus, Buffalo; Dr. James F. Rooney, Albany; Dr. J. Stanley Kenney, New York; Dr. Louis J. Bauer, Hempstead; Dr. Frank L. Sullivan, Scotia.

Representatives of the Commission:

Dr. Basil C. MacLean, presiding; Dr. Harold R. Brown; Dr. Andrew E. Eggston; Assemblyman Leonard Furberstein; Dr. Robert L. Levy; Mr. Garrard Winston; Dr. Paul A. Lemboke, Director of Study. Not present: Dr. Weiskotten, Senator Hammer.

The Medical Society representatives stated that since the first proposal for compulsory medical insurance was introduced in this country in 1912, organized medicine has been unalterably opposed to it. The movement for compulsory medical insurance was characterized as "a stimulated demand" unsupported by any need in New York State or the United States.

It was indicated that anyone in need of care can get it, and the belief that people who need care often forego it rather than apply to public or charitable institutions was discounted. Thus, a compulsory plan would not increase the quantity of care; it would merely make it easier to pay for. Care available at present is not used fully because of lack of demand and interest, it was said, and no provision of law could substitute for the process of gradual education as to health needs. The chief objection to the proposals of the Commission was that they are compulsory and so may lead to State medicine - to the State directing physicians when to work and how to work, and leaving physicians with no protection against arbitrary orders and interference.

With regard to the specific plans, it was felt that all physicians' services should be on an indemnity basis and that different fees should be allowed in different areas. If a plan were to be adopted, home and office visits should be added to or substituted for physicians' services in hospitals, to reduce the anticipated demand for unnecessary hospitalization. Also, any plan that might be effected should be limited to persons below a specified income limit, perhaps \$3,000 for a family.

The program of the Medical Society was set forth as the development of voluntary medical care plans throughout the State which would provide surgical, medical and obstetrical care on an indemnity basis for in-hospital patients. Such voluntary plans, together with laboratory diagnostic facilities if necessary (services to be paid for by patients), additional hospitals for acute and especially chronic cases, care of the indigent at public expense under voluntary plans, and an extended program for preventive diseases, would be sufficient, it was believed.

In related correspondence with the Chairman, President Cunniffe signified the willingness of the State Medical Society to continue discussions with the Commission, but asked that the discussion also include other plans. It would be unfair, he said, to expect the Medical Society to ac-

cept any responsibility for a compulsory plan, because it is not acceptable in principle. Exception was taken to the membership of the Commission as not providing proper representation of the Society:

After your Commission was in existence for a year^{2/} a bill was passed in the subsequent session of the Legislature increasing it by two members and the Medical Society was privileged to recommend their names. This we do not feel is a proper representation. We feel also that the medical men on the Commission hold opinions not in sympathy with those held by the profession in our state. We also feel that it would be of great value in developing plans for improving medical care if members of our Medical Society who have had a great deal of experience in delivering medical care, would be present at all discussions and have a vote in determining which plan would be acceptable.

Private Medical Care Plans

Representatives of the medical plans:

Dr. Leo Simpson and Sherman Meech, Genesee Valley Medical Care, Inc; Winslow Carlton, Group Health Cooperative of New York City; Dr. Dean A. Clark, Health Insurance Plan of Greater New York; Dr. Leo E. Gibson and J. Campbell Butler, Central New York Medical Plan, Inc. of Syracuse; Dr. F. M. Miller, Jr., and H. C. Stephenson, Medical and Surgical Care, Inc. of Utica; Rowland H. George, Dr. Harry Sesan and Mr. Descher, United Medical Service, Inc. of New York City; Dr. R. C. Kimball, Consolidated Edison of New York, Inc.; Mrs. E. N. Hill, R. N., Ansco Division; Miss Helen Neilson, industrial medical service used by several Binghamton industries; Robert L. Eckelberger, Endicott-Johnson Corp.; Dr. H. H. Bauckus and Carl M. Metzger, Western New York Medical Plan, Inc.; Dr. John E. Heslin, Albany.

Representatives of the Commission:

Dr. Basil C. MacLean, presiding; Dr. Harold R. Brown; Assemblyman Leonard Farbstein; Senator Frederic E. Hammer; Dr. Paul A. Lembcke, Director of Study. Not present: Dr. Levy, Dr. MacKenzie.

The large number of participants speaking from individual viewpoints at times produced views that were at variance. The group were essentially agreed that the issue of compulsion was one to be decided by the Legislature, and abstained from commenting on it. The major suggestion concerning benefits was that any division of physicians' services should be between types of service, e.g., surgical or medical, rather than between the places where the service would be rendered, e.g., home and office, or in-hospital service. If surgical services were to be offered, it should be made possible to render them in home, office or hospital, and the same would be true of other types of service. The desirability of preventive, diagnostic and other home and office services was conceded, but many of

^{2/} The first meeting of the Commission was October 21, 1944. The law authorizing the two additional physicians was enacted in January 1945, and the appointments were made in June 1945.

the speakers stressed the danger of excessive use. Opinion was also divided on the necessity for group practice, but there seemed to be no objection to it on a permissive basis. However, some persons thought that general home and office service could be provided economically only by groups, either on a fee-for-service or, preferably, on a capitation basis. With one or two exceptions, all were agreed that the voluntary, industrial, union and other private plans should be encouraged to continue by means of crediting premium payments against tax liability. Some persons found the indemnity provisions of the plan objectionable, but others thought it would be the only method of securing the immediate participation of physicians. If the operation of the plan worked out to pay full fees to physicians, and if they found also that they were receiving payment for patients who had previously paid little or nothing, they might be willing to waive the right to make extra charges.

New York Academy of Medicine

Representatives of the Academy:

Dr. Cornelius P. Rhoads, acting President; Dr. George Baehr, Dr. Iago Galdston, Dr. Malcolm Goodrich.

Representatives of the Commission:

Dr. Robert L. Levy, presiding; Dr. Harold R. Brown; Dr. Andrew E. Eggston; Assemblyman Leonard Farbstein; Dr. Basil C. MacLean; Mr. Garrard Winston; Dr. Paul A. Lembcke, Director of Study; Mr. Leon Fischel representing Assemblyman Mailler. Not present: Dr. Godfrey, Dr. MacKenzie, Senator Joseph.

The Academy representatives agreed that something should be done to improve the current pattern of distribution of medical care, but were not in agreement with the Commission or among themselves on methods to be employed or the worth of the Commission's tentative plans. The plans were criticized as not conferring sufficient importance on group medical practice, and in not allowing to beneficiaries the choice of selecting physicians on either a capitation or a fee-for-service basis. Medical groups should be incorporated by physicians, not hospital or dispensary boards, it was said. The plans were also criticized as being compromises or half-way measures. The group urged that the Commission devote more time to study and preparation, and that it be guided by the Academy's studies, the results of which could not be disclosed until some months later, however.

In a news report the new President of the Academy is quoted as voicing "definite opposition" to President Truman's plan for Federal compulsory health insurance, but stating that "it may be desirable to conduct careful experiments at State and local levels with compulsory government insurance."^{3/}
3/ PM, January 4, 1946.

Hospital Association of New York State, and Greater New York Hospital Association

Representatives of the State Hospital Association:

Harold A. Grimm, Millard Fillmore Hospital, Buffalo; Bernard McDermott, Long Island College Hospital, Brooklyn; John F. McCormack, Presbyterian Hospital, New York City; Carl P. Wright, Syracuse General Hospital, Syracuse.

Representatives of the Greater New York Hospital Association:

Dr. Morris Hinenburg, Jewish Hospital, Brooklyn; Dr. Claude W. Munger, St. Luke's Hospital, New York; Dr. John B. Pastore, New York Hospital, New York.

Representatives of the Commission:

Assemblyman Lee B. Mailler, presiding; Dr. Lucien Brown; Assemblyman Leonard Farbstein; Dr. Frederick MacCurdy; Miss Marion W. Sheahan; Dr. Paul A. Lemboke, Director of Study.

It was the opinion of the hospital representatives that it should be the governing boards of hospitals rather than the medical staffs which should be authorized to form medical groups. The point was made that in a plan providing physicians' services only to hospitalized patients, the physician who does not have a hospital staff appointment would be involuntarily excluded from participation, but no immediate solution was offered to this problem. Another question raised concerned the possibility that if every patient had a private physician, internes and resident physicians would have little chance to perfect their medical skills by caring for staff patients, as they now do. It was thought that many hospitals might have to form medical groups in order to continue their teaching services to internes, but others present saw little reason why internes could not continue to learn by caring for patients under the guidance of private physicians and under the general supervision of the teaching staff of the hospital, if the hospital chose to so arrange.

The two hospital associations agreed to form a joint committee for further study of the Commission's tentative plans, and to submit a memorandum concerning methods of payment of hospitals, preservation of clinical teaching opportunities, group practice, and guarantee of autonomy to hospitals. The following report was later submitted by the President of the New York State Hospital Association:

The Hospital Association of New York State has always advocated proper and adequate health care for every inhabitant of our State.

Accordingly, the Association appreciated the opportunity afforded to discuss this mutual objective with members of your Commission through a special committee comprising President McCormack, Secretary Wright, Harold A. Grimm, Bernard M. McDermott and Dr. George Wheeler on Tuesday morning, September 11.

At the close of our conference, this committee was requested to

file a statement with your commission, which we are very glad to do.

While no committee has any authority under our Constitution to commit the Association membership to or for any project, it was our desire that the recommendations to your Commission represent the thinking of the widest possible range of our membership and accordingly called together the Presidents of our eight regional hospital councils and our Executive Committee on September 21st.

At this conference, your first draft of a tentative plan for medical care was carefully analyzed and the following suggestions represent the thinking of those present.

It ~~must~~ be thoroughly understood by the Commission that the Hospital Association is not expressing an opinion in favor of compulsory health insurance. As a matter of fact the sense of the hospital field is clearly and strongly opposed to it.

With that understanding, we offer the following basic principles which we believe should be included in any program, to wit:

1. Full and comprehensive medical, dental, hospital and nursing care should be made available for every inhabitant in our state.
2. The autonomy of the non-profit voluntary hospital should be maintained.
3. The hospital educational program for doctors, nurses, residents, interns, medical students and technicians should be encouraged and not interfered with in any way which might jeopardize future medical care.
4. Hospitals should be fully reimbursed for their services. It is our carefully considered opinion that under any state wide program hospitals will cease to be recipients of financial assistance from Community Chests and other philanthropy and must depend solely on their earnings.
5. Non-profit voluntary prepayment hospital plans should be allowed to continue, maintaining their autonomy, with the provision that they shall fully reimburse hospitals for the services rendered to their subscribers.
6. Should any state-wide plan for hospital care be adopted, hospitals should be adequately represented and have the right to nominate candidates for membership on whatever state authority is created. We refer your Commission to the method used for years by the Board of Regents in selecting representatives of physicians, hospitals and nurses on the Nurse Advisory Board.

The report also asked certain questions concerning details of the plan, such as inclusion of anesthesia as a hospital service; the necessity for smaller hospitals to provide social service, physiotherapy, anesthesia and laboratory service; group practice; payment to chiefs of medical staffs; etc. With regard to approval or licensure of hospitals, it was stated that the hospitals would "welcome one authority and one real inspection, and the avoidance of further duplication of authority and inspection."

New York State Dental Society

Representatives of the Dental Society:

Dr. Donald Miller, Elmira; Dr. Theodore Kaletsky, New York; Dr. Stanley G. Standard, New York; Dr. Harry Strusser, New York.

Representatives of the Commission:

Senator Frederic E. Hammer, presiding; Very Rev. John J. Bingham; Dr. Andrew E. Eggston; Dr. E. S. Godfrey; Dr. George M. MacKenzie; Assemblyman Lee R. Mailler; Miss Marion W. Sheahan; Dr. Paul A. Lembcke, Director of Study.

The Dental Society representatives, at the conference and in a memorandum, stated their belief that as citizens the dentists had the right to agree or disagree with the principle of compulsory insurance, but that as a profession they did not have the right to tell the people what they should do. Accordingly, they limited their recommendations to methods by which the people might obtain the best service under a plan such as was presented for discussion. Although in agreement with the philosophy of a controlled dental program along preventive lines, they took exception to the methods of administration and payment for services.

It was suggested that the State administrative agency should have as an associate or assistant administrator, a dentist who would direct the dental aspects of the program. Beneficiaries should be permitted to pay more to dentists for more costly service, as permitted in the case of physicians' services. The system of pro-rating payments was not favored. The suggested fee schedule should be refined and revised. Municipal and other local dental groups or clinics should be permitted to take cases on an annual or per session basis, rather than fee-for-service. The sum allotted for dentistry was considered adequate for prevention and the care of dental disease as it arose, but not for the correction of accumulated dental defects; however, the program would probably not be used fully at the beginning, and the available moneys would be sufficient to treat accumulated neglect as well as to provide current care.

Recommendations were made that funds be allotted for dental research and for basic training and refresher courses in children's dentistry. Although dental specialists are not recognized as are medical specialists, the program should define certain services as specialist services and recognize dental specialists. Dentists should be permitted to prescribe laboratory examinations and hospital admissions in the case of dental infection. The provision of emergency dental service for adults, i.e., extractions and treatment of focal infection, should be considered.

New York State Nurses Association

Representatives of the Association:

Miss Hortense Hilbert, Bureau of Nursing, New York City Health Department; Miss Clare Casey, President, New York State Nurses Association; Mrs. Tessa Klein, Buffalo Visiting Nurse Association; Miss Elizabeth Hall, Executive Secretary, New York State Nurses Association.

Representatives of the Commission:

Senator Frederic E. Hammer, presiding; Msgr. John J. Bingham; Dr. E. S. Godfrey; Dr. George M. MacKenzie; Assemblyman Lee B. Mailler; Miss Marion W. Sheahan; Dr. Paul A. Lembcke, Director of Study. Not present: Miss Hall, Miss Gelinas*.

Subsequent to the conference, which was of a general exploratory nature, the following memorandum was sent to the Commission by Miss Casey:

The Advisory Committee of Nurses chosen to confer with the New York State Commission on Medical Care held a conference on September 20th at the Hotel Pennsylvania. In attendance were:

Elizabeth Hall	Executive Secretary, New York State Nurses Association
Hortense Hilbert	Director of Public Health Nursing, New York City Department of Health
Grace A. Warman	Director of Nursing Service, Mt. Sinai Hospital, New York
Mrs. Tessa M. Klein	Director of Nursing, Visiting Nurse Association, Buffalo, New York
Clare M. Casey, Chairman	Director of Nursing, Beth Israel Hospital, New York
*Agnes Gelinas, Guest	Member, Board of Directors, New York State Nurses Association

The Committee reviewed the Commission's plans for medical insurance, agreed on certain principles (and raised certain questions^{4/}) as follows:

1. It was agreed that there is need for a state-wide medical care plan.
2. The compulsory contributory feature of the proposed plans and financing by individual contribution and taxation were believed to be sound.
3. Since frequent reference is made to "adequate" medical care, questions arose as to the definition of "adequacy" in this respect and as to the methods contemplated for informing the public relative to the meaning of "adequacy of care."
4. The guiding principles (as stated on Page 5 of the first draft of plans) for medical insurance were approved in essence.
5. It was the unanimous opinion of the Committee that there should be provision for wider nurse representation on the Commission inasmuch as a large portion of the hospital service provided for under these plans is nursing and inasmuch as home nursing service is provided for in addition, it would seem reasonable that representation from both fields be included.

In addition to the principles agreed to above, the memorandum raised certain questions (See Footnote 4) and made specific recommendations and suggestions (summarized because they referred to pages and section numbers of the booklet), of which the outstanding ones were: More comprehensive benefits should be offered. Dental care should be extended to more persons. The scope of nursing care should be broadened to include antepartum

^{4/} For the reasons stated therein, the questions are summarized in the paragraph following this memorandum.

and postpartum visits; also, more adequate provision should be made for hourly or daily nursing care in the home. More adequate local representation should be afforded in connection with administration, and approval of nursing standards and agencies. Provision should be made to advance the education of personnel involved in giving care under the plan.

New York State Council of Retail Merchants

This group was represented in the person of John C. Watson, in the conference with Associated Industries.

Associated Industries of New York State, Inc.

Representatives of Associated Industries:

Ralph M. Andrews, Executive Vice President of Buffalo Chamber of Commerce; Frank B. Cliffe, General Electric Co.; Mark A. Daly, Executive Vice President, Associated Industries; Martin F. Hilfinger, President, Associated Industries; John C. Watson, New York State Council of Retail Merchants.

Representatives of the Commission:

Assemblyman Leonard Farbstein, presiding; Mr. Robert T. Lansdale; Dr. George M. MacKenzie; Mr. Garrard Winston; Dr. Paul A. Lembecke, Director of Study; Mr. Leon Fischel representing Assemblyman Mailler. Not present: Dr. Weiskotten.

This conference centered around a lengthy written appraisal of the plan by Mr. Cliffe. The group deferred a definite stand on the question of compulsion until legislation should actually be introduced, but felt that a State plan would be preferable to a Federal plan because the latter would be too complicated to be administered from the Federal level. The provision of adequate medical service for children, and preventive care without cost as a deterrent, was suggested. The Commission's plan was characterized as one wherein the cost of medical care would be more widely distributed and carried in larger part than at present by (a) those who are not sick within a given period, (b) those who have incomes above the average, and (c) some payment from every individual in the State having any appreciable income; the payment on account of those who are dependent would be made by the general taxpayers who are already furnishing their support.

It was thought that employers should not be required to share the tax with employees. Certain large corporations have avoided locating in New York State because of taxes which are already high. Even under the Commission's proposals, employers would be making some contribution because of the cost of withholding taxes from wages, and there would undoubtedly be pressure from employees for increased wages to compensate

for the wage-deductions of taxes for medical insurance. The administrative problems involved in tax and individual premium collection were pointed out, and it was thought that the suggested method of withholding taxes from wages would need revision, because otherwise the status of employees would vary and would require differing withholding rates. 1941 was preferred to 1943 as a "normal" year for estimating taxable income.

Some element of co-insurance, i.e., the individual should individually carry some part (a percentage of the fee, or cost of first visit, etc.) of the cost of service rendered, was suggested as a means of preventing excessive use of service.

The benefits offered were considered adequate, except that more complete service for children was recommended. Some of the minor services omitted could be paid for individually, as at present, which would tend to minimize administrative problems and to concentrate the financial resources of the plan upon the points of greatest need. Undoubtedly there would be some abuses, such as patients being hospitalized unnecessarily, but the fact that the State does not have a superabundance of hospital facilities would automatically act as a control.

Commerce and Industry Association of New York

Representatives of Association:

John A. Cahill, President, City and Suburban Homes Co.; Dr. Haven Emerson, College of Physicians and Surgeons; Prof. Thorndike Saville, Dean, College of Engineering, New York University; Harry Waltner, Jr., Standard Oil Co. of New Jersey; M. William Zucker, Acting Director of Research, Commerce and Industry Association; Frank B. Cliffe, General Electric Company; Ralph Hawkins, New York Telephone Company; Timothy J. Mahoney, the Borden Company, Chairman of the Commerce and Industry Association. Committee on Social Legislation; Edmund B. Whittaker, Prudential Life Insurance Company.

Representatives of the Commission:

Assemblyman Leonard Farbstein, presiding (second meeting); Very Rev. John J. Eingham; Mr. Robert T. Lansdale; Dr. George M. MacKenzie; Dr. Basil C. MacLean, presiding (first meeting); Dr. Robert L. Levy; Mr. Garrard Winston; Dr. Paul A. Lemboke, Director of Study; Mr. Leon Fischel representing Assemblyman Mailler.

Two conferences were held with this group. At the first conference, the material for discussion had not been received sufficiently in advance to permit discussion of details. The Association group was not convinced that there was any need for action by the State in the field of medical insurance, but would prefer State to Federal legislation. It was recommended that the role of the State be confined to providing hospital and related physical facilities for medical care. The answer to the health

problem was thought to lie in public education, and assistance to institutions. The Commission was advised to concentrate on the Federal (Hill-Burton) Hospital Construction Act and existing public health services, and forget about medical insurance.

The second conference centered around written questions proposed by the Association, from which they developed the following suggestions: To limit abuses, each case should be scrutinized professionally in order to insure that hospital care was actually a medical necessity. Technics should be developed to make certain that a high quality of medical care would be rendered. Physicians should be guaranteed full payment of fees to secure their cooperation. The State advisory council should have authority to inquire into, originate, suggest, and report publicly upon, the conduct and result of the services, but should have no authority over personnel or expenditures. Each physician licensed by the New York State Board of Regents should be guaranteed hospital facilities in order that his patients might be covered by the program.

Persons who for religious or other reasons did not desire to receive medical care should not be compelled to contribute to the program. The proposed tax on localities should be eliminated since it might be an entering wedge for changing all of the tax from an individual tax to a general government tax. Also, it should be guaranteed that any increase in revenues would come from taxes on the individual rather than general taxes. Fees should be variable according to size of community or some similar factor.

An annual physical examination might be more worthwhile than some of the other benefits included in the plans, and should be substituted for them.

A specified proportion of income of the insurance fund should be allocated by law for health educational purposes.

State Charities Aid Association

Representatives of the Association:

Homer Folks, Secretary, Miss Elsie Bond, Assistant Secretary; Peter Cantline, Board of Managers; George Nelbach, Assistant Secretary, State Charities Aid Association.

Representatives of the Commission:

Dr. Basil C. MacLean, presiding; Dr. Robert L. Levy; Mr. Garrard Winston; Dr. Paul A. Lembcke, Director of Study; Mr. Lee Dowling representing Mr. Lansdale; Mr. Leon Fischel representing Assemblyman Mailler.

The Association members, speaking as individuals, stressed their interest in public health measures for control and prevention of disease, as well as for some type of medical insurance program. They were pleased with the steps taken in the Commission's proposals to remove medical care from the welfare field, but emphasized the need for preventive medicine and thought that the public would be disappointed if the Commission did not recommend more comprehensive benefits.

They felt that the administrative problems to be faced in providing out-of-hospital benefits could be overcome if payment were not on a fee-for-service basis. If revenues were to be limited, they recommended that the benefits for which the greatest need exists, complete diagnostic service before illness becomes catastrophic, be provided without cost to the individual. Such service, provided through efficiently operated centers, would fill a more important need at present than physicians' care in the hospital, since once a patient is admitted to a hospital some sort of physicians' care is arranged, inadequate though it may be. However, many persons are unable to afford diagnostic service and thus permit illness to progress until hospitalization is required. In view of this, if funds were limited, Plan 3, modified to include services in diagnostic centers, would be preferred.

New York State Grange

Representatives of the Grange:

Henry D. Sherwood, Master; Harold M. Stanley, Secretary; Kenneth H. Fake.

Representatives of the Commission:

Assemblyman Leonard Farbstein, presiding; Very Rev. John J. Bingham; Mr. Robert T. Lansdale; Dr. George M. MacKenzie; Dr. Paul A. Lembcke, Director of Study; Mr. Leon Fischel representing Assemblyman Lee Mailler. Not present: Mr. Winston.

The Grange representatives said that they did not feel entirely qualified to gauge the attitude of farmers on the matter of compulsory health insurance because, although the Grange had recorded its opposition to "state medicine," the Commission's proposals would not necessarily fall within this category. The reaction of the agricultural group could be judged only after they had been provided with an opportunity to become thoroughly acquainted with the Commission's plan or plans. The attitude of the farmer would be influenced in large part by farm prices; the purchase of medical care is largely an economic problem to the farmer, and if farm prices were high he would be more likely to look with favor on

the proposals. Farmers are interested in insurance plans and a number have joined, but in a number of areas they find it difficult to get together with other farm families to form an acceptable group.

If a compulsory plan were enacted, the farmers would feel discriminated against if they were excluded, or covered only through voluntary enrollment. If employer contributions were required, the farmer would not feel that he should pay an amount equal to the total tax paid by employee and employer, but would want to be charged the same tax on income that was levied on the employee alone. If a plan were adopted, care should be taken to assure adequate hospital facilities in rural areas.

Farm people are opposed to any type of class preference, and would want the rural physician to be paid on the same basis as the urban physician. The provision of both service and indemnity benefits was thought desirable.

Cash income would seem to be the only practical basis for taxation. It would be possible to make some check on farm income through examination of records of payments by dairy, poultry and other produce buyers.

Life Insurance Association of America

Representatives of the Life Insurance Association:

Henry S. Beers, Vice President, Aetna Insurance Co.; Reinhold Hohaus, Associate Actuary, Metropolitan Life Insurance Co.; Wendell A. Milliman, Vice President, Equitable Life Assurance Society; Albert Pike, Assistant Actuary, Life Insurance Association of America.

Representatives of the Commission:

Mr. Garrard Winston, presiding; Dr. Andrew E. Eggston; Assemblyman Lee B. Mailler; Dr. Paul A. Lembcke, Director of Study. Not present: Dr. MacCurdy, Senator Joseph.

The life insurance group preferred action on a voluntary basis rather than through government, but thought that if it appeared desirable to experiment with government plans, this should be done at the local or State rather than at the Federal level. Government programs for protection against communicable diseases, and tax-supported hospitals for mental and nervous diseases, have demonstrated that government financial support and supervision do not necessarily mean government administration, and also that government programs in the health field may be good or bad depending on the program rather than on the presence or absence of government.

If a public program were introduced, it would be essential to have the cooperation of physicians. The respective fields for voluntary and governmental action should be carefully worked out through cautious experimentation, utilizing existing machinery as much as possible. There

should be an extension of health centers, equipped with a laboratory and with other instruments of precision, staffed by specialists familiar with all of the modern medical devices, and available for diagnosis and treatment. This would reduce the cost of adequate medical care and would have a continuing postgraduate impact upon the general practitioner himself, since their facilities would aid him in maintaining high standards of practice.

Providing physicians' services in the hospital only might result in excessive hospitalization. Benefits should be very clearly defined lest there be continued pressure for broader interpretation of the services. Caution should be exercised in paying differential fees which might lead to provision of benefits primarily by specialists, and so to overspecialization in medicine. The physician who is not affiliated with a hospital presents a problem.

If it was not found possible to provide comprehensive benefits for the entire population, they should be provided for children, at the least.

The importance of obtaining the cooperation of physicians, particularly in the matter of setting up the fee schedule, was emphasized, since if this were not done, benefits could not be guaranteed. Much of the difficulty in obtaining the cooperation of the physicians would lie in the prorating feature, it was thought, and the suggestion was made that the beneficiaries rather than the persons rendering service bear the burden of any excess of expenditures over income. Funds for medical insurance should be segregated, and no funds from general State revenues should be used, because a plan supported by general revenues is more susceptible to pressure for added revenues to pay the full value of the unit, more benefits, greater liberality in interpretation for eligibility, etc. The use of service by eligible persons might be more conservative if they had to make a direct contribution toward the cost. Medical insurance taxes should not be mixed with general income taxes, even though difficulties would be encountered in collecting a per capita tax from low-income groups. The justice of taxation of non-residents, who are not eligible for benefits, was questioned. It was thought that the cost figures used by the Commission might not correspond with actual experience, since it is difficult at present to work them out for services other than hospitalization.

As far as possible, agencies with experience should be used to administer the plan, but it is doubtful whether anyone has had sufficient experience to handle such a large undertaking, with its need for adequate controls.

Health and Accident Underwriters Conference

Representatives of the Health and Accident Underwriters:

W. Franklyn White, Assistant Secretary, Mutual Benefit Life Insurance Co.; John M. Powell, President, Loyal Protective Life Insurance Co.

Representatives of the Commission:

Mr. Garrard Winston, presiding; Dr. Andrew E. Eggston; Assemblyman Lee B. Mailler; Dr. Paul A. Lembcke, Director of Study. Not present: Dr. MacCurdy, Senator Joseph.

This group thought that the State should not enter the field of health insurance, because more evils would result than if nothing were done. If a plan were adopted, it should be limited to persons below certain income limits. The indemnity provisions proposed by the Commission were similar to those offered by commercial companies, whose experience has been that the public reaction is very unfavorable when the physician charges in excess of the fee allowed by the company. The propriety of taxing non-residents was questioned.

It was thought that under the Commission's plan private companies could offer comparable benefits and compete with the State if they were permitted to enroll subscribers on a group basis. Too much latitude should not be given to local administrative authorities lest they become subject to political patronage.

Bureau of Personal Health and Accident Underwriters

Representatives of the Personal Health and Accident Underwriters:

J. F. Follman, Jr., Manager of the Bureau, and Ralph M. Brann, Secretary-Treasurer of the Bureau of Personal Accident and Health Underwriters.

Representatives of the Commission:

Mr. Garrard Winston, presiding; Dr. Andrew E. Eggston; Assemblyman Lee B. Mailler; Dr. Paul A. Lembcke, Director of Study. Not present: Dr. MacCurdy, Senator Joseph.

This group did not consider itself qualified to state the views of the personal health and accident insurance companies and recommended that the Association of Casualty and Surety Executives be consulted in its stead.

Association of Casualty and Surety Executives

Representatives of the Casualty and Surety Executives:

Richard C. Wagner, Manager of Casualty Department, and Counsel;
and Frank Lang, Research Director of the Casualty and Surety
Executives.

Representatives of the Commission:

Dr. Basil C. MacLean, presiding; Dr. Lucien Brown; Assemblyman
Leonard Farbstein; Mr. Garrard Winston; Dr. Paul A. Lembcke, Di-
rector of Study; Mr. Leon Fischel representing Assemblyman Mailler.

This group felt that if compulsory insurance were to be enacted, a State plan operating through existing insurance channels, such as proposed by the Commission, would be more acceptable than a national plan. However, difficult administrative problems would be encountered in evaluating benefits offered by private plans, and in the mechanics of allowances and deductions in tax returns.

Standardization of benefits would be necessary under the State plan to simplify evaluation of the benefits offered for purposes of tax deduction, and to include the minimum benefits required by the State. At present, private company health insurance policies are not standardized to any extent; they include in some measure hospitalization, surgery and, occasionally, obstetrics, but not medical care in the hospital nor certain of the other benefits included in the State plan.

A difficulty would arise in paying for benefits, since private companies pay the beneficiary rather than the person or agency rendering service. Under a State system, payment would have to be made directly to the person rendering service. The State Insurance Law (Section 164) would probably have to be changed to permit companies to do this, and they might be inconvenienced because the New York State policies would not then correspond to those written in other States to conform with national agreement for uniformity. Consideration should be given to including in the State plan a co-insurance clause requiring the patient to share the initial cost of treatment, or to establishing a maximum for the payments on behalf of any one beneficiary, as is done to some extent by the non-profit voluntary medical care plans.

New York State Industrial Council, CIO

Representative of CIO:

Morris Iushewitz, Research Director, New York State Industrial Council, CIO.

Representatives of the Commission:

Dr. Basil C. MacLean, presiding; Dr. Lucien Brown; Assemblyman Leonard Farbstein; Mr. Garrard Winston; Dr. Paul A. Lembcke, Director of Study; Lee Dowling representing Mr. Lansdale; Mr. Leon Fischel representing Assemblyman Mailler.

Mr. Iushewitz stated that the Committee on Social Legislation, New York State Industrial Council, CIO, had carefully reviewed the Commission's proposals and that the views he expressed were not personal, but those of the Committee. He submitted a detailed memorandum prepared by the Committee on Social Legislation. After stating the need for a compulsory health insurance system and the inadequacy of voluntary plans to meet it, and after commending the Commission for adopting several progressive principles, the memorandum went on to characterize the Commission's plans as wholly insufficient to meet the need of an adequate program of medical care because of the unnecessary limitations upon the benefits provided, because of the restrictions upon the medical practitioners who may participate in rendering services under the plan, and because of the burdensome provisions upon low-income groups for taxation to obtain funds for the program. Limitations of space make it possible to present here only the criticisms and proposals for improvement that were made in the memorandum.

1. Criticism. The restriction upon the rendition of medical service only in a hospital makes the medical service available to the people wholly inadequate. It will exclude from medical care a large majority of the people who requiring medical attention do not require hospitalization. It will exclude from participation in the plan a large number of qualified doctors who are not members of hospital staffs.

Proposal: A universal medical plan such as this purports to be should make provisions for complete medical care for all ailments by all the people. A social plan of this nature has various aims including the prevention of serious ailments and diseases, the rendition of medical attention whenever required, not only from those who can afford to pay but by all people. Medical service limited to a hospital vitiate these aims.

Medical service should be rendered not only at a hospital but at the home of the patient or at the office of the doctor as required, depending upon the gravity of the ailment and should be provided by doctors not only on hospital staffs but by any and all physicians who desire to participate in this social plan

by becoming part of a group project.

2. Criticism. The fiscal provisions of the plan are burdensome on low-income groups, many of whom are now entitled to free medical care provided by localities and welfare districts. The fiscal provisions contravene the principles of progressive taxation in imposing a flat annual premium of \$7.50 for every resident 18 or over and a 1.75% income tax on all whose income is as low as \$500 but limiting the application of the tax to only \$5,000 of the income of any person.

Proposal: a) The \$7.50 annual premium should be eliminated.
 b) There should be an income tax not exceeding 2% for each person without dependents earning not less than (\$); and for each person with dependents earning not less than (\$), such tax should be levied on total income and not be limited to \$5,000 of income.
 c) The payment by welfare districts should be increased, or the State should make an additional contribution for recipients of public assistance.

3. Criticism. The limitation of group practitioners to the governing boards or staffs of hospitals or dispensaries unnecessarily and unjustly penalizes doctors who are not members of hospital staffs.

Proposal: Any group of qualified doctors associating themselves for practice as a group should be authorized to render services under the plan.

4. Criticism. The limitation upon payment for services by the Commission based only on fees for service is too restricted and improperly excludes other methods of payment better adapted in many instances to the rendition of services under a plan for medical insurance.

Proposal: Payment to physicians should be on (1) a fee basis, according to a fee schedule approved by the Commission, or (2) a per capita basis, according to the number of individuals on a practitioner's list, or (3) a salary basis, for whole or part time service, or (4) a combination or modification of these as the Commission may approve after consultation with the practitioners involved in any locality or group.

5. Criticism. The dental services provided are too limited even at the beginning of the program.

Proposal: Dental care should be provided for all children up to age 17, and the Commission should be authorized to extend such service from time to time to other classes of persons.

6. Criticism. The plan is deficient in one other major respect in failing to provide for cash benefits during unemployment due to sickness. This is an essential feature of any comprehensive health insurance program and the Commission should propose such a provision in its recommendation to the Legislature.

In commenting on the memorandum, Mr. Iushewitz emphasized that the CIO's support of coverage for all residents of the State, rather than persons in industrial employment only, was disinterested. Many industrial workers are now protected by medical insurance or are negotiating with employers for such coverage. Persons not employed in industry are the ones who are most in need of protection.

The CIO is backing the Wagner-Murray-Dingell Bill for a national health insurance program, which is preferred to State legislation, but in the absence of immediate Federal legislation, the Council would like to see New York State take the lead. Although cash sickness benefits are desired, the Commission's plan would not be opposed simply because it lacked them. The various union health plans might provide excellent media for operating the State plan in part.

If the individual premium were reduced considerably, it might be viewed more favorably by the CIO. An individual tax with no upper income limit would be preferable to employer contributions because of the difficulty of obtaining universal coverage under the latter arrangement. Although coverage on an individual basis with employer contribution would be easier to develop and administer than universal coverage, it would not be as desirable from the standpoint of general public interest.

Other Groups

It was originally planned to hold conferences with certain other representative groups before November 1, 1945, but time and other factors did not permit. Among the other groups considered, or who had on their own initiative requested conferences, were: Associations of town, county and municipal welfare and administrative officers, New York State Veterans Commission, American Legion, Veterans of Foreign Wars, Association of Civil Service Employees, Farm Bureau, League of Women Voters, Hospital Council of Greater New York, Research Council on the Problems of Alcohol, State Parent-Teachers Association, Physicians Forum, New York City Chapter of National Lawyers Guild, Christian Science Committee on Publications, New York Clothing Unemployment Fund Agency, New York State Conference of Farm Organizations, New York State Public Health Council, and others. All groups making requests were furnished with the booklet of study proposals, Alternative Plans for Medical Insurance. Memoranda or letters were received from some of them, and also from other

organizations whose members had become familiar with the material through participation by some of their members in the conferences. Such memoranda are summarized in this section.

New York Clothing Unemployment Fund Agency (Tax Department). A single social service department should be created to administer health insurance along with Unemployment Insurance and Workmen's Compensation. Benefits should be comprehensive and should include all medical, hospital, nursing and related service. The Commission's cost estimates were considered to be too high. Cash benefits should be paid for temporary disability due to illness or maternity, and for permanent disability. Financing should be by general taxes.

Buffalo Chamber of Commerce. Consideration should be given to the encouragement of health insurance on a voluntary basis, through an educational program. If health insurance were to become available through State or Federal legislation, a State program would be preferred. After comparison of the Ives Bill and the Commission's proposals, it was recommended that: Every resident of the State should be covered. The only equitable method of covering all persons would be for individuals to contribute in accordance with their ability, by tax and a flat fee. Existing private profit and non-profit insurance agencies should be encouraged to continue through permitting individuals to deduct the cost of premiums (up to a certain amount) from required contributions to a State health fund. The cooperation of the medical profession would be necessary to assure the widest possible choice of practitioner, and ways and means to secure such cooperation should be studied.

Physicians Forum. Many features of the Commission's proposals were commended, but the plans as a whole were disapproved because of lack of comprehensive benefits, employment of the fee-for-service principle, permission for the physician to make extra charges, limitation of organized medical groups to hospital and dispensary staffs, undue financial burdens on low-income groups, and lack of specific provision for post-graduate education of physicians. Medical insurance should be handled on a Federal rather than a State basis.

Christian Science Committee. Compulsory health insurance in general was opposed. If adopted, any law should permit persons to choose their own method of treatment and they should not be compelled to undergo medical examination, supervision or treatment in order to receive

health or other benefits, if it were contrary to their religious convictions.

National Lawyers Guild, New York City Chapter. A thorough and lengthy analysis made essentially the criticisms and proposals made in the CIO report. Comprehensive benefits, with financing by a general income tax, were recommended. In a separate section on group practice, it was recommended that both partnership practice, and group practice by non-profit corporations composed of any group of physicians (not limited to hospital or dispensary staffs), should be authorized under a medical insurance program, subject to State supervision.

Louis H. Fink.^{5/} The following suggestions were made as personal, unofficial ones, not binding on, but characterized as representing:

....the sincere desire of the Associated Hospital Service of New York and the entire Blue Cross movement to cooperate fully with any sound program for a more comprehensive and efficient health service for the people of the United States.

If all of the forces in the State and community were united in offering improved hospital and medical care to all, regardless of financial status, a compulsory plan probably would not prove necessary. A compulsory program was opposed on the general ground that it would stifle inspiration and progress, and would entail sameness, bureaucracy, lessening of local initiative and responsibility, and a tightening of the control of government over physician-patient relationships.

The Sage Health Center Bill of 1920 (reviewed in an earlier chapter) was viewed favorably, and it was suggested that it be adapted to the needs of the present. State-aid should be granted for research, scholarships and other medical education, and dental clinics for school children. One-half of the cost of erection of hospitals, health centers and clinics should be met by the State. Financial assistance for operation of official and voluntary hospitals and clinics should be granted by the State where income from patients and local public funds proved insufficient. The government should enroll veterans in Blue Cross plans.

If compulsory payments for medical care proved necessary, they should apply on behalf of employed persons and their families, with the employer being free (as under Workmen's Compensation) to self-insure or to obtain insurance from a stock company, mutual company or State fund.

^{5/} A Health Plan for the State of New York, Memorandum Prepared for New York State Commission on Medical Care, December 11, 1945.

Where family earnings are under \$2,100 per year (less in rural areas), the employer and the State and local governments should share the cost. Where family earnings are between \$2,100 and \$3,500 (less in rural areas), employer and employee should share the cost. Individuals receiving over \$2,000 and families receiving over \$3,500 should pay the full cost.

CHAPTER XVIII
PUBLIC OPINION ON MEDICAL INSURANCE

There is no doubt that great public interest and concern exists relative to the means by which medical care should be provided. To learn the wishes of the people as definitely as possible, a number of surveys have been undertaken by various organizations, some covering the United States as a whole and others being limited to a single State. This chapter summarizes the results of such surveys, but does not cover the survey of public opinion conducted for the Commission by Surveys Incorporated, the results of which are presented in PART 3 of the report.

In the interest of brevity and pertinence, there have been summarized only those phases of the surveys concerned with the means by which medical care should be provided. All of the surveys were conducted by public opinion or market research organizations skilled in this work, and it may be assumed that the results are truly representative. It must be kept in mind, however, that the questions asked and, therefore, the answers received, vary from survey to survey, depending somewhat upon the attitude of the organization responsible for the survey. Special attention should be paid to the nature of the questions in order that the answers may be properly interpreted.

"What Do the American People Think About Federal Health Insurance?"

This survey was conducted for the Physicians' Committee on Research, by the National Opinion Research Center, University of Denver, in August 1944. The entire United States was covered. Some of the highlights of the survey follow:

1. If you could get some insurance for which you paid a certain amount each month to cover all the doctor care you might need in the future, would you rather do that, or would you rather pay the doctor what he charges you each time?

Prefer to pay in advance	55 per cent
Prefer to pay each time	38
Don't know	7

2. Would you be willing to pay \$3 a month if you were assured complete doctor and hospital care for you and your family any time in the future you might need it?

Willing to pay \$3. per month	67 per cent
Not willing to pay \$3. per month ...	25
Don't know	8

3. Do you think it would be a good or a bad idea if the Social Security Law also provided for paying for the doctor and hospital care that people might need in the future?
- Good idea 68 per cent
 Bad idea 19
 Don't know 13
4. If $2\frac{1}{2}$ per cent of people's pay checks would be taken out instead of the present 1 per cent, would you think this a good idea or bad idea?
- Good idea 58 per cent
 Bad idea 10
 Don't know 13
 (The remaining 19 per cent had replied to Question 3 that inclusion of medical insurance under Social Security would be a bad idea.)
5. Would you rather have the Social Security law handle the insurance that would pay for people's doctor and hospital bills, or would you rather have it handled through some private insurance plan?

Social Security 48 per cent
 Private insurance 13
 Don't know 20
 (The remaining 19 per cent had replied to Question 3 that inclusion of medical insurance under Social Security would be a bad idea.)

"Public Relations of the California Medical Profession"

This survey was conducted for the California Medical Association by Foote, Cone & Belding in November 1943. Only persons resident in California were questioned. Some of the highlights of the survey follow:

1. Do you think we should have some sort of a socialized government-controlled medical plan?
- Yes 50 per cent
 No 34
 Don't know 16
2. If you were asked to choose between one of these plans for medical care, which would you prefer?
- Our present system of voluntary practice ..., 36 per cent
 Voluntary pre-payment plan which entitles you to the services of any doctor you choose 31

Government-controlled plan supported
by tax funds which entitles you to
~~the~~ services of government-employed
doctors in your community 23

Voluntary pre-payment plan which
entitles you to the services of
the doctors employed by a clinic
or medical center 4

Don't know 7

3. If you were asked to choose between one of these plans for ob-
taining hospital service, which would you prefer?

Our present system 33 per cent

Voluntary pre-payment plan which
entitles you to the services of
any hospital you choose 31

Government-controlled plan sup-
ported by tax funds, which
entitles you to the services of
a government-operated hospital
in your community 25

Voluntary pre-payment plan which
entitles you to the services
of a clinic or medical center
hospital 4

Don't know 7

"Public Relations of the Medical Profession, State of Michigan"

This survey was conducted for the Michigan Health Council by Foote,
Cone & Belding in June and July 1944. Only persons resident in Michigan
were questioned. Some of the highlights of the survey follow:

1. Do you think we should have some sort of a government operated
medical hospital plan?

Yes 38.7 per cent
No 42.8
Don't know 17.9
No answer..... 0.6

2. If you were asked to choose between one of these plans for medi-
cal hospital care, which would you prefer?

A voluntary pre-payment plan which
entitles you to the service of any
doctor or hospital you choose - spon-
sored by the medical profession and
hospitals..... 33.7 per cent

Our present system of private practice..26.6

A government-controlled plan supported by tax funds which entitles you to the services of government-employed doctors in your community15.5

An insurance company plan under which you would receive an amount of money for which the policy was issued, and you would make your own financial arrangements with the doctor and hospital 13.4

A pre-payment plan operated by a labor union 0.9

Don't know..... 8.7

No answer 1.2

3. Do you favor the organization of groups of salaried doctors offering complete medical care in the home, office and hospital?

Favor plan controlled by government....15.9 per cent

Favor plan controlled by medical profession21.7

Favor plan controlled by labor unions 1.1

Total favoring such a plan38.7

Do not favor such an organization at all.....41.0

Don't know 19.3

No answer 0.5

4. If you are not married, and a medical hospital plan covering hospital and surgical expense only cost you \$1.50 per month, would you:

Pay \$.25 additional per month for medical service in addition to surgical service while in the hospital?

Yes73.9 per cent

No 13.2

Don't know 12.9

Pay \$1.75 additional per month for complete medical and surgical care in home, doctor's office and hospital?

Yes46.5 per cent

No.....34.4

Don't know 19.1

5. If you are married, and a medical hospital plan for your entire family covering hospital and surgical expense only cost you \$4.00 per month, would you:

Pay \$1.00 additional per month for medical service in addition to surgical service while in the hospital?

Yes	55.9 per cent
No	21.3
Don't know	12.8

Pay \$4.00 additional per month for complete medical and surgical care in home, doctor's office or hospital?

Yes	34.4 per cent
No	47.7
Don't know	17.9

"Three Publics Appraise Prepayment Medical Care"

This survey was conducted for the National Physicians Committee for the Extension of Medical Service, Inc.^{1/} by Opinion Research Corporation, in 1945. It is believed that the entire United States was covered. Inasmuch as the results of the survey were available only in the form of an interpretive report, it is not possible to show the exact questions and responses, except where indicated by quotation marks. The reader is thus at some disadvantage because he does not know how "group-insurance", "Federal government plan", "doctor organization plan", etc. were described. It was stated, however, that the descriptions were limited to sponsorship, and that such factors as benefits, coverage, cost, freedom of selection of doctor, etc. were omitted or minimized.

1. 77 per cent thought something should be done to make it easier for people to pay for doctor and hospital care.
2. 53 per cent admitted experiencing hardship in meeting medical bills at some time.
3. 40 per cent stated that they were familiar with cases where others had foregone treatment because of financial stringencies.
4. What method would help most to ease the financial burden of medical care?

Prepayment plan	54 per cent
National health insurance	13
Control of doctors' prices.....	7
Welfare or charity for indigent	4
Installment payments.....	3
Teach people to save.....	2
Organize an association	2
Miscellaneous	3

^{1/} The leaders of the National Physicians Committee are for the greater part the leaders of the American Medical Association.

5. Which type of plan would you prefer, -

Government sponsored?	41 per cent
Non-government sponsored?	36

(After a brief description of the two types)

Government sponsored	45 per cent
Non-government sponsored	43

6. Those who have heard of "group insurance" think it a

Good idea	55 per cent
Fair idea	19

Those who have heard of the "Federal government" plan think it a

Good idea	49 per cent
Fair idea	18

Those who have heard of "doctor organization" plans, think them a

Good idea	38 per cent
Fair idea	24

7. Which type of plan would you prefer to have for yourself?

Group insurance plan	39 per cent
Government plan	34
Doctor plan	12

8. Do you think the Federal government plan would be good or bad for the nation as a whole?

Good	55 per cent
Possibly good	8

9. Reasons for favoring private plans -

People would not be compelled to pay	24 per cent
Doctors and insurance companies would do better work in open competition	22
Would make more effort to please	19
Would be more efficient	19
No interference with free enterprise	17
Stronger personal relationship	12

10. Reasons for opposing private plans -

Many people would not join unless compelled to do so	30 per cent
Doctors would not cooperate	19
Cost more than government	19
Variability of types, incomplete coverage, lack of cooperation of employers, etc.	remainder

11. Reasons for favoring government plan -

Would assure people more medical care	38 per cent
Would force people to protect themselves against medical expenses	25
Would assure more care to people in rural areas and small communities	23
Would provide care at lower cost	23

12. Reasons for opposing government plan -

Too much red-tape and political influence	42 per cent
Freedom of choice of doctor would be curtailed	23
Doctors would take less interest in their patients	22
Destroy doctors' ambition, threat of socialism, lower quality of care, etc... remainder	

13. "If you had no insurance at all, which of these kinds of insurance would you consider it most important to have?"

Life insurance	50 per cent
Hospitalization insurance	26
Sickness benefits	26
All types	16
General doctor bills	14
Surgical benefits	13

"Should Industry Support Federal Health Insurance"^{2/}

This was the subject of a ballot among some 50,000 subscribers to Modern Industry, a "substantial proportion" of whom vote. The results were:

	Per cent	
	Yes	No
New England	41.7	58.3
Mid-Atlantic	55.0	45.0
North Central	46.1	53.9
South	48.8	51.2
West	38.8	61.2
Pacific Coast	52.5	47.5

Among those voting "No", a significant proportion added "strike out the word 'federal' and I will vote yes."

"Should We Have Compulsory Health Insurance"^{3/}

This was one of a series of a "Poll of Experts" conducted by Dr. Arthur Kornhauser and published in the American Magazine. The panel of experts voted as follows:

^{2/} Modern Industry, July 15, 1945.

^{3/} American Magazine, January 1946.

1. The American people should be protected by some form of health insurance

Yes 99 per cent

2. This insurance should be compulsory and operated by the Government

Yes 60 per cent

(Among physicians on the panel, the vote was: Yes - 50 per cent; No - 50 per cent. Among social and economic authorities - not physicians - the vote was: Yes - 75 per cent; No - 25 per cent)

President Truman's Plan

This was a survey conducted in the District of Columbia by the Washington Post Poll.^{4/}

"The President has suggested that a small amount be paid from a worker's wages into an insurance fund that would help pay doctor, dentist and hospital bills for the worker and his family. Do you approve or disapprove of the plan?"

Approve	70 per cent
Disapprove	21
Don't know	9

"Highlights of a Survey on the Associated Hospital Service of New York"

This survey was conducted for Associated Hospital Service of New York in May and June 1943 by the Elmo Roper organization, and reported under the above title by Frank Van Dyk, Vice President of Associated Hospital Service.

1. When asked why they were not insured, the non-enrolled employees of firms participating in hospitalization insurance replied most frequently:

Financial reasons - couldn't afford it.
 Don't feel I need it - I'm never sick.
 I already have another form of hospitalization.
 Just never interested - never thought about it -
 never got around to it.

2. Concerning cancellations, the most frequent replies were:

Financial reasons - couldn't afford it ...	25.4 per cent
Had paid in for years and never used it -	
not getting out what they have paid in ..	15.9
Took another plan which offered more	
benefits	11.1

3. When asked what they felt was not good about the plan, almost 50 per cent gave the reason that the plan did not include doctor bills, and about 20 per cent felt that the plan did not include sufficient benefits.

^{4/} Washington Post, January 28, 1946.

4. When asked what inducement would have to be offered to persuade them to enroll, more than one-half stated that the plan should pay all or part of the doctor's bill.

Comments

In spite of the different questions asked, and the different areas covered by the surveys, there can be no doubt that a majority of people want insurance covering hospital and medical expenses. They are willing to pay directly for such insurance if the costs are not too high.

It appears that the people are not primarily concerned with the question of government or private sponsorship. Their concern is that a plan shall be available which will not only benefit them personally, but which will benefit all of the people. They apparently think that a government plan would reach more rural people and more low-income people than would a private plan. Where the questions have not implied that government would tell people what physician and hospital they must use, they seem to be favorable toward a government plan.

CHAPTER XIX

POPULATION COVERAGE UNDER MEDICAL INSURANCE

Various groups of the population may be covered under State or national medical insurance programs, depending upon the medical needs of such groups, economic status, occupational status, relative ease of administration and collection of premiums, and available moneys. Table 1 shows the coverage afforded by 27 national health insurance plans, and the variations among them.

Dependents

Health insurance had its beginning in the payment of cash indemnities to persons who were absent from work due to illness, the cash payment being intended to serve the dual purpose of compensation for loss of wages and of affording the means by which a ill or disabled worker could purchase medical care. This type of insurance of necessity was limited to wage-earners, but it soon became apparent that illness was less likely to be prolonged and that better health results would be obtained if, in addition to cash benefits covering loss of wages, medical service was provided to the insured. Except for private (commercial) companies, practically all insurance plans, compulsory and voluntary, now provide medical service, which has facilitated the transition to inclusion of dependents.

A number of national plans as yet do not cover spouse and children, and this is also true of many voluntary plans sponsored by labor unions and industries.^{1/} However, the trend is steadily toward inclusion of all family members in both voluntary and compulsory medical insurance, and existing plans of all types are broadening their coverage in this direction.

Economic Status

Limitation of insurance to persons and families below a certain economic level is attributable to a class concept which is foreign to American philosophy, i.e., the concept of a low-paid working class. Insurance for such a class more nearly resembles a scheme for forced savings to avoid public expense (combined with fixation of some responsibility upon the employer for the health and welfare of his low-pay employees), than as a straight insurance system. The early history of plans sponsored by medical societies discloses that at first insurance was to be limited to persons and families below a certain income. This did not prove popular,

^{1/} See Table 1, Chapter XII.

Table 1. Population Coverage Afforded by National Compulsory Health Insurance Plans^{1/}

COUNTRY	OCCUPATIONS COVERED			INCOME LIMIT FOR		DEPENDENTS COVERED		Ages Covered	Percentage of Population Covered
	Wage Earners (Manual Workers)	Salaried Employees	Others	Manual Workers	Others	Wife	Children		
AUSTRIA.....	Commerce Industry Mining Agriculture Personal Services	Commerce Industry Mining Agriculture Personal Services				X	X		66%
BULGARIA.....	All	All				No	No		31%
CHILE.....	All	All	X	12,000 pesos	12,000 pesos	No ¹	No ¹	All under 65	30%
CZECHOSLOVAKIA.....	All	All	X			X	X		47%
DENMARK.....	All ²	All ²	All ²	4,200 kroner ³	4,200 kroner ³	No ⁴	X	21 to 60	80%
IRE.....	All	All		None	£250	No	No	All over 16	16%
ESTHONIA.....	Industry Mining Navigation Buildings	Industry Mining Navigation Buildings	Small masters			Optional	Optional		
FRANCE.....	Industry Commerce Agriculture	Industry Commerce Agriculture	Home-workers	15,000 to 25,000 francs	15,000 to 25,000 francs	X	X	13 to 60	50%
GERMANY.....	All	All	X	None	3600 R.M.	Optional	Optional		66%
GREAT BRITAIN.....	All	All		None	£420	No	No	14 to 65	40%
GREECE.....	All	All							
HUNGARY.....	All except agricultural workers	All		None	3600 pengo	X	X		
ITALY.....	Industry Commerce Transport Agriculture Seamen and Airmen	Industry Commerce Transport Agriculture Seamen and Airmen			9600 lire	In some schemes only	In some schemes only		22%
JAPAN.....	Industry Mining			1200 yen		No	No		3%
LATVIA.....	All	All	X			Optional	Optional		
LITHUANIA.....	All but agricultural workers	All	None	4800 litas	4800 litas	X	X		
LUXEMBURG.....	All	All	None	None	10,000 francs	No	No		
NETHERLANDS.....	All	None	None	3000 florins		No	No		
NEW ZEALAND.....	All	All	All	£208 ⁵	£208 ⁵	X	X	All ^{a/} over 16	100% ^{b/}
NORWAY.....	All	All			4500 kroner	No	No	All over 15	20%
PERU.....									
POLAND.....	All except agricultural workers	All	Home-workers	8700 zloty	8700 zloty	X	X		7%
PORTUGAL.....	Trade union members	Trade union members							
RUMANIA.....	All except agricultural workers	X	X	72,000 lei	72,000 lei	X	X		
SWITZERLAND ⁶									
U.S.S.R.....	All	All	All	None	None	X	X		100% ^{b/}
YUGOSLAVIA.....	All except agricultural workers	All	None			X	X		

¹ Consideration now being given to extending scope to dependents.² Either actively or passively insured.³ Limit for active insurance.⁴ Expected to be insured in her own right.⁵ Limit for receipt of cash benefits only.⁶ Considerable variation in schemes.^{a/} Ages covered refers only to requirement for payment of registration fee.^{b/} Added by Commission from supplementary data.^{1/} Health Insurance, Special Committee on Social Security, House of Commons, Ottawa, 1943. Credited to Approaches to Social Security: An International Survey, International Labour Office, Montreal, 1942.

and restrictions were changed so that "service" benefits were for those below a certain income, while those above such income limit would receive "indemnity" benefits.^{2/}

This distinction still holds in many plans, but the trend seems to be toward writing all policies as indemnity policies, with a proviso that if the charges exceed the amount stipulated in the fee schedule, and if a subscriber is below a certain income level, an individual appeal may be made to a review board for adjustment or elimination of charges in excess of the schedule. This device seems to have been necessitated by the reluctance of prospective subscribers to divulge their income as a condition to enrollment in a plan, and by the fact that after enrollment, income status may change markedly for better or for worse.

A compulsory medical insurance plan has two great advantages to offer: (1) spread of risk among a large population group, and (2) contributions toward the cost of care for below-average income persons or families by those of above-average income. If persons above a certain income limit are excluded from benefits, they must contribute nevertheless through general taxation on behalf of those below such income limit. Because it does not seem equitable to deprive them of the first advantage, if any distinction is to be made it should be to limit the above-average income group to indemnity benefits.^{4/}

Persons who are wholly or partly dependent upon public assistance for their subsistence have usually been excluded from coverage, being expected to receive their medical services from public welfare agencies. However, they may be included, as in New Zealand, as a matter of right or, as proposed in several State and national plans, by payment of premiums on their behalf by the public assistance agency responsible for their support.

Occupational Status

There are two important considerations which have tended to limit coverage to persons in certain occupations. The first is simplicity of tax collection. Because revenues for some part of the cost of a majority of plans are based on wages and salaries rather than on total income, col-

^{2/} "Service" means that for a specified service the physician or agency rendering care agrees to accept the stipulated payment by the insurance agency as full payment. "Indemnity" means that for a specified service the physician or agency may exercise the right to charge the patient in addition to the fee received from the insurance agency.

^{4/} Another device for combining "service" and "indemnity" provisions in the same plan is described in Chapter XXI.

lection of a percentage of wages and salaries is obtained with difficulty and at a high rate of administrative cost from persons irregularly employed, or engaged in occupations such as agriculture and domestic service where the number of employees per establishment is small and where payments in kind rather than in cash often enter the picture. Persons in such occupations are not excluded because they do not need coverage (in fact, they may need it more than the others), but rather because of the difficulties and costs of collection. The second consideration is the possibility of obtaining contributions from employers. This is a device which makes the beneficiary think he is getting something for nothing, and tends to gain popular support for an insurance plan, although in reality the employee must pay indirectly, in the form of increased prices of goods and services, for the cost of the plan.

Another consideration is partly attributable to development of health and social insurance systems at a time when salaried workers had a much greater measure of security than wage-earners. Governmental employees often have their own medical and other types of insurance systems, and are usually excluded from compulsory plans. Also, Federal employees cannot be included under a State employer-employee financed plan because a State cannot tax the Federal government. The employees of local governments may be included, however. Within the past year, it has been made legal for municipalities to contribute one-half of the cost on behalf of their employees.^{5/}

If coverage is limited to certain occupations (usually termed "covered employment"), it is necessary to fix a minimum level of earnings or contributions bearing some relation to the annual value of the insurance. Otherwise, a person enjoying a good income from other sources might participate in covered employment for only a very short period and contribute only a nominal amount, yet benefit extensively from the insurance.

In a State plan a residence requirement should be imposed if general funds are to be used to supplement employer-employee contributions. If this were not done, non-residents would benefit at the expense of residents who contributed to the plan through general taxes.

Age

The column entitled "Ages Covered" in Table 1 in most instances refers to the ages of contributors, rather than to beneficiaries, and is thus significant only for those plans which do not provide benefits to depend-

ents, e.g., Chile, Eire, Great Britain and Norway.

Another type of plan, which departs somewhat from the insurance principle, would limit coverage to persons in certain age groups (initially, at least). Under the proposed Maternal and Child Welfare Act of 1945 (S. 1318, 79th Congress), grants-in-aid to the States would be provided for maternity services, and for medical, dental, hospital and related services to children under 21 years of age. The States individually would be free to provide such services with or without a means test.^{6/}

The outstanding characteristic of a plan limiting coverage to children is that health, like education, is considered to be a right to which every child is entitled. There would seem to be two outstanding advantages in this type of plan. First, the greatest need and hope for accomplishment in the prevention of disease and disability lies with children in the formative years of life. Second, it would entail only a modest cost, and the experience obtained in its administration would be helpful in reaching a decision as to whether, and in what form, a plan with broader coverage should be developed subsequently.

Universal Coverage

The trend in medical insurance as in other forms of social security is toward covering all groups and classes of the population as a matter of citizenship, rather than ministering to only certain classes on the basis of administrative simplicity, expediency, or the concept of a fixed class composed of low-income industrial workers. New Zealand, Denmark, the U.S.S.R. and, to a great extent, Switzerland, cover the entire population, and Canada, Great Britain,^{7/} Chile, etc., have such plans under serious consideration. Modern administrative methods and tax-collection devices make possible the fulfillment of the desire expressed by the people of New York State^{8/} that all persons should be covered.

Exclusions

Some plans accord recognition to certain groups which because of religious beliefs will not use medical benefits, by excluding them from benefits and exempting them entirely from making contributions. However, it

^{6/} Although the Children's Bureau Advisory Committees on Maternal and Child Health are reported as advocating determination of eligibility by the State health agency (Journal of the American Medical Association, 130: 228, Jan. 26, 1946), States would presumably be free to use or not to use a means test in determining eligibility.

^{7/} It is worthy of comment that the British plan was developed prior to the advent of the present Labour Government.

^{8/} See Chapter XVII and PART 3.

is fundamental in a compulsory plan that people of above-average income contribute on behalf of those below the average. It would seem, therefore, that if persons were to be excluded from benefits because of religious beliefs, the tax exemption should not exceed the actual value of the benefits.

CHAPTER XX

BENEFITS

Benefits Generally

The benefits provided under national compulsory health insurance plans have been illustrated in Table 5 of Chapter XV. Only general practitioner service, maternity care, hospital care and drugs are offered by a majority. A number offer medical appliances, but only a few include surgical treatment, specialist service, dental or preventive benefits. In some instances surgical service is provided as a part of care in hospitals, especially public hospitals, either as a part of the compulsory plan or in connection with public medical services. In a majority of plans benefits are available for a period of only 26 weeks, although some plans provide for a longer, stated period, and some prescribe no limit.

It is characteristic of plans proposed in this country that surgical and specialist, as well as general medical service, are included. Hospital care is also furnished, and x-ray and laboratory diagnostic services are usually included. As a rule, only limited dental benefits are provided because of the high cost and the lack of personnel. Drugs are very rarely specified for inclusion, probably because the administrative costs involved would be very high in relation to the value of the drugs, and because over-prescribing and the use of expensive or worthless proprietary remedies are difficult to prevent.

Services Excluded

Exclusions are generally made on the basis of an accepted or legally fixed public or private responsibility. In theory it may not be necessary to make the customary exclusions because many of such services can be handled on an actuarial basis, but in practice it may be best to do so in the interest of simplicity and economy.

Public responsibility. The care of tuberculosis after diagnosis is usually excluded because this disease is best cared for in special hospitals which provide the services of specially-trained physicians as an integral part of the care. Also, the control of tuberculosis depends on case finding and case control measures which require highly specialized and integrated facilities and personnel for mass examinations, follow-up examinations, and the like. The public would seem to be entitled to the reductions in costs and to the high grade of service which has been developed over the period of 40 years or more in which tuberculosis programs have been operated as public medical services. Hospitalization of the

tuberculosis patient benefits the community as much as it benefits the patient, and the cost thereof should be a wholly public charge, as is now provided under New York State law for patients eligible for admission to county tuberculosis hospitals, and as should be provided for other subdivisions of the State.^{1/}

The care of mental disease after diagnosis is usually excluded on the same general grounds as tuberculosis.^{2/} The institutional treatment of chronic addiction to drugs or alcohol also requires specialized facilities and personnel; it is a public health problem also, and the cost should be borne by the community at large.^{3/}

Other medical procedures excluded are those which are public health functions of departments of health, education, labor and mental hygiene: the prevention or control of the spread of communicable disease, study of the prevalence of disease and health hazards, and determination of fitness for school or employment.^{4/}

Individual and collective private responsibility. Care in schools for the blind and the deaf, and the departments of institutions such as orphanages, county homes and jails, is excluded because the provision of medical care therein is considered to be an integral part of the custodial care. Institutional care of the chronically ill is also excluded when it appears that such care is largely domiciliary rather than restorative in character and is, therefore, a subsistence rather than a medical need.

^{1/} The requirement that a patient pay if he is judged able to do so by welfare department or similar standards undoubtedly prevents a number from entering hospitals and becoming non-infectious. The result of this policy is often a continued spread of the disease, and continuing costs to the public for the care of cases attributable to the first. Further, the amount collected by tuberculosis hospitals from individual patients is so small that it is questionable whether it significantly exceeds the costs of financial investigations and collections.

^{2/} As in the case of tuberculosis, to be consistent with the objectives of a medical insurance plan, the present practice of charging patient or relatives for care in a mental hospital should be discontinued.

^{3/} At present, patients with these conditions cannot be admitted to State mental hospitals unless some other type of mental disease is present. Amendment of the Mental Hygiene Law to permit admission of this type of patient to State mental hospitals and to authorize the establishment of special hospitals for the care of these conditions would be necessary to conform to the objectives of a medical insurance plan.

^{4/} There would be retained to departments of health, mental hygiene, education and labor, the application of disease investigation and control methods, health education, school health service, case finding by mass methods, study of occupational hazards, etc., - all of which are essentially community procedures. Examples are: examination of tuberculosis contacts, mass surveys for diagnosis of tuberculosis or syphilis, examination of food handlers, school medical inspection, etc.

Care in any institution required by law to provide hospital care without cost to the recipient, such as marine hospitals or veterans hospitals, is also usually excluded because the responsibility has been fixed upon a certain agency rather than upon contributors to an insurance plan.

The costs of care of diseases and disabilities which have been defined by law as the responsibility of an employer, such as Workmen's Compensation cases, or as the responsibility of an individual, such as injuries resulting from an auto accident, are excluded.

Medical and surgical treatment for purely cosmetic reasons is usually excluded, but such exclusion does not embrace such procedures as plastic surgery for the remedy of scars, contractures or other congenital or acquired disfigurement.

Although physical examination for the purpose of diagnosis may be included, examinations to determine fitness for employment, attendance at school and the like are generally excluded as being a matter of public or private responsibility outside of the scope of an insurance program.

Type of Payment for Benefits

Under private (commercial) insurance plans, benefits consist of cash payments to beneficiaries for specified illnesses. In some contracts it is required that the beneficiary substantiate the fact that he has paid or has been billed by a physician, hospital, etc., for the care of such illness. In other contracts proof of illness may be required, but it is not necessary to show that the cash payment to be received from the insurance company will be used for medical expenses. The danger inherent in this method of payment for benefits (which was at first the only method approved by the American Medical Association) is that beneficiaries may not use the money for medical care, thus negating the objective of the medical insurance plan. Another danger is that the participating physician, etc., may not be assured of his payment. Also, the method does not lend itself readily to payment for complete service; e.g., laboratory service as part of hospital care.

The better method, and the one which is generally employed, is to make payment directly to the physician, hospital, or other person or agency providing service.

Cost of Professional Services Generally

The task of estimating the cost of professional services is fraught with uncertainty and beset by prejudice. There is little to be gained by

comparison of annual or per capita costs among plans unless fee schedules, content of services and type of population served are comparable, as they seldom are. Costs may be related to average income of physicians with some certainty, but at this point there enters the element of evaluation of the worth of a physician's service. To some persons an average net income per physician of \$9,000 per year would seem inordinately high, to others it would seem fair, and to still others it would seem relatively low in view of the exacting demands of medical practice and the long and costly period of preparation.

Perhaps the most important factor in estimating costs is to present the full data on which costs are estimated, and to relate them to volume of service. If this is done, adjustments which may seem necessary in the light of later developments can be made on logical grounds. In the following sections an attempt is made to correlate the estimated cost of benefits with anticipated needs and current practice. One fact to be borne in mind is that gross income and net income should be clearly distinguished. The individual practice of medicine is a form of business, and expenses for office rent, drugs and supplies, instruments, transportation and other items amount to 35 or 40 per cent of gross income.

The estimates which follow have been made with the expectation of satisfying all real medical needs under circumstances where no financial barrier exists, and when all beneficiaries have been educated to the availability and desirability of securing complete medical service. During the first years of operation the plan might not conform in total or in its constituent parts to the estimates made, both by reason of incomplete utilization of some services, and over-utilization of others where there is a backlog of accumulated needs, e.g., surgical operations to correct defects which have not caused marked disability.

Physician Service

If the number and type of services required are known, the cost may be computed by applying a fee for each service. Utilizing the data on services required for adequate medical care^{5/} after adjustment to the age distribution of New York State^{6/} population, and fees based upon the New York State Workmen's Compensation Fee Schedule^{6/} (see Table 1) the cost

^{5/} The Fundamentals of Good Medical Care, R. I. Lee and L. W. Jones, Publication No. 22 of the Committee on the Costs of Medical Care, University of Chicago Press, 1933.

^{6/} Minimum Medical Fee Schedule, Division of Workmen's Compensation, New York State Department of Labor.

of adequate medical care per 1,000 population of all ages was computed, the results being shown in Table 2.^{7/}

Several factors must be kept in mind with regard to Table 2. First, the costs embrace all medical services that would be provided directly to individuals, with the following exceptions: treatment of tuberculosis; treatment of psychosis, feeble-mindedness, neurosis, behavior problems and institutionalized cases of neurosyphilis; health supervision, and communicable disease case-finding and control as ordinarily carried on by public health departments and school health services; and periodic physical examinations of apparently well individuals. Second, the fact that a medical insurance program would compensate certain classes of physicians, especially surgeons, for services now provided without cost to staff cases, the indigent, etc. might justify lower fees for such type of service. On the other hand, certain fees perhaps should be increased. It is possible that the two changes might be compensatory. This fee schedule was employed because it has an official basis and because it has, in general, served as a model for the fee schedules adopted by voluntary medical insurance plans.

Exclusive of x-ray, physiotherapy and eye refraction, the cost of complete physician service is estimated to be \$19.52 per person per year - \$12.12 for general practitioner, \$3.61 for specialist service other than operation and \$3.79 for surgical operations.^{8/} The actual expenditures for physician service in New York State in 1944-45 is estimated at \$15.27 (see Table 3 of Chapter IV). In Chapter XIII it was estimated that for 1,000 of population 1,796.1 physician-hours would be required to provide these services. At the estimated cost of \$19,522, the annual gross earnings per physician devoting 1,440 hours per year to seeing patients would be \$15,675 gross, or about \$9,400 net. To earn this amount, a physician would have to work full time and provide all care for an average population of about 300 persons. On an hourly basis, his net earnings (at 60 per cent of gross) would be \$6.52 if no allowance were made for time spent in travel, study, waiting for patients, the business end of practice, etc. If an allowance of an additional 50 per cent of his time were made, his net hourly earnings would average \$4.34

Table 3 shows what the average annual earnings of New York State's estimated 24,422 practicing physicians would be on the basis of \$19.52

^{7/} See Chapter XIII for general description of the Lee-Jones Study and its adaptability to present conditions.

^{8/} Compare with per capita surgical costs shown in Table 6, Chapter XII.

Table 1. Fee Schedule Employed in Computing Costs of Physicians' Services, X-ray and Physiotherapy (Based upon New York State Workmen's Compensation Fee Schedule) ^{a/}

General practitioner visits		X-ray examinations by physician within his competence	
Home		Chest	\$ 11.00
First		Encephalogram	18.00
Subsequent		Fractures, diagnosis and follow-up (average)	8.00
Office or hospital		Gall-bladder series	20.00
First		Gastro-intestinal	
Subsequent		Colon	15.00
Specialist, consultation and routine treatment visits		Upper intestinal tract.	25.00
Home		Genito-urinary	
First*		Simple.	11.00
Subsequent.		Pyelograph by excretion	18.00
Office or hospital		Retrograde pyelograph	11.00
First*.		Joints, (average)	8.00
Subsequent.		Mastoid	11.00
Obstetrics		Simuses	11.00
Prenatal visits (same as home or office)		Spine, one region	11.00
Delivery and postpartum care		X-ray examinations by general practitioner	
Miscarriage		Simple fracture, diagnosis and follow-up (average).	4.00
Operative		X-ray therapy	
Uncomplicated		Deep (tumor).	15.00
Special procedures		Superficial (dermatitis, etc.).	5.00
Allergy tests		Surgery (no allowance made for anesthetist or for assist- at operation)	
Cystoscopy		Anal and lower rectal	50.00
Simple, without x-ray		Appendectomy	100.00
With catheterization of ureters		Arthrodesis	100.00
Hemorrhoid injections		Brain surgery, tumor.	300.00
Hydrocele, tapping.		Cataract extraction or needling (average)	100.00
Refraction by ophthalmologist		Cholecystectomy, etc.	250.00
Syphilis treatment		Excision, resection, etc. for peptic ulcer.	150.00
Intravenous		Glaucoma operation	100.00
Intramuscular		Hemorrhoidectomy	
Physiotherapy, any type		External, single	25.00
Fractures, reduction and after care		Internal or multiple external	50.00
General practitioner or specialist		Hydrocele, radical.	50.00
Wrist, fingers, ribs, clavicle, face bones, etc		Hysterectomy, ovariectomy, salpingectomy, etc	150.00
Arm		Incision and drainage, including after care	15.00
Leg and ankle		Kidney, calculi removal	150.00
Skull		Nephropexy	150.00
Specialist: as above, and		Nephrotomy	100.00
Skull, operative.		Orchidectomy.	60.00
*Complete examination by neurologist or psychiatrist.		Pelvic repair	100.00
*Simple office check-up on referred patients, by ophthalmologist		Prostactomy	250.00
*Refraction by ophthalmologist.		Semi-lunar cartilage removal	100.00
		Spinal fusion, repair bow-legs, etc. (average).	175.00
		Thyroidectomy	150.00
		Varicocoele.	50.00

^{a/} See also subsequent sections covering x-ray fees.

Table 2. Cost of Physician Services per 1,000 Population in Providing Adequate Medical Care at Workmen's Compensation Fees, New York State

Disease category	General practitioner	Specialist		Total physician
		Consultation & treatment	Operation	
Respiratory	\$5,082.66	\$ 597.22	\$ 604.28	\$6,284.16
Digestive	896.92	297.85	1,722.69	2,917.46
Acute communicable	720.92	80.04	40.74	841.70
Injuries	898.39	261.54	50.36	1,210.29
Puerperal	968.42	206.35	-	1,174.77
Syphilis & gonorrhea	620.55	513.71	-	1,134.26
General diseases	555.07	143.71	468.29	1,167.07
Skin	154.27	54.73	4.81	217.86
Female genital	216.52	21.60	261.90	560.02
Ear & mastoid	91.56	194.99	11.83	298.38
Muscles, bones, etc.	128.38	103.61	81.20	318.19
Kidneys & annexa	371.49	220.55	269.36	961.40
Heart & arteries	871.08	27.71	-	898.79
Eye & annexa	14.78	396.06	12.95	423.79
Circulatory	66.75	52.36	39.22	157.33
Male genital	6.81	10.81	137.45	155.07
Neuralgia, etc.	131.24	51.26	-	182.50
Neurasthenia, etc.	223.58	35.25	-	308.83
Nervous & mental	99.78	145.80	65.07	310.65
Total	12,119.17	3,614.20	3,789.15	19,522.52
Eye refraction	-	947.8/	-	-

a/ Based on assumption that one-half of refractions would be performed by ophthalmologists at \$7.50, and one-half by optometrists at \$4.00

per capita. The average earnings figures in Table 3 are somewhat lower than that of \$9,400 net calculated for the theoretical average physician inasmuch as not all physicians are capable of working the full time required.

The data in Table 3 may be compared with national average earnings of \$14,341 gross and \$9,186 net reported for 1943.^{9/} Although the State

Table 3. Estimated Annual Average Gross Earnings of Physicians, by District, in Providing Adequate Medical Care at Workmen's Compensation Fees, New York State

District	Practicing physicians	Persons per physician	Average income	
			Gross	Net ^{b/}
Albany	1,276	743	\$14,537	\$8,722
Buffalo	1,527	756	14,790	8,874
Rochester	1,271	741	14,494	8,696
Syracuse	1,743	760	14,856	8,914
New York ^{a/}	18,605	543	10,626	6,376
State ^{a/}	24,422	593	11,590	6,954

a/ Adjusted by adding 1 million to population base.

b/ 60 per cent of gross

Medical Society considers the Workmen's Compensation fees to be too low,^{10/} and although some critics have felt that they are too high, such data as are available tend to support the belief

^{9/} "Specialists' Economic Status" Medical Economics, October 1945. Figures are for all physicians, including specialists, who were in active practice and who derived less than 50 per cent of their income from salaries.

^{10/} Minutes of the Annual Meeting, House of Delegates, Medical Society of the State of New York, New York State Medical Journal, 46:195, January 15, 1946.

that they are sufficiently representative of current costs to be used as a basis for estimating the cost of benefits under a State-wide medical insurance plan.

Cost under program providing complete medical care. To provide adequate medical care at the fees employed, the cost of physician service for 13.75 million people would be: general practitioner - \$166,638,588; specialist, consultation and treatment - \$49,695,250; specialist, operation - \$52,100,813; total - \$268,434,650. However, these figures must be adjusted to exclude costs for which employers and others would be liable under Workmen's Compensation and private liability laws. In 1943, insurance companies paid out \$69.25 million,^{11/} and self-insurers an estimated \$18 million,^{12/} a total of \$87.25 million, under Workmen's Compensation. Of this sum, 30 per cent was for medical benefits, of which about 70 per cent or \$18.32 million was paid to physicians.^{13/} Deducting this sum and \$4 million arbitrarily estimated as payable under other liability laws, leaves approximately \$245 million payable for physician service under a medical insurance plan.

When varying amounts are added for x-ray, radiotherapy, laboratory diagnostic services and physiotherapy, as indicated in subsequent sections, the total cost, exclusive of eye refraction, is about \$258 million, the figure employed in Plan 1, Table 1 of Chapter XVI. This sum is made up of general medical and surgical service - \$245 million; x-ray service - \$10 million; laboratory service (electrocardiogram, basal metabolic rate determination, etc.) - \$1.5 million; physiotherapy - \$0.8 million; and miscellaneous - \$0.7 million. The per capita expenditure for physician service for beneficiaries would thus be about \$18.76.

Cost for surgical and obstetrical care - home, office and hospital. The figure of \$72 million employed in Plans 2 and 4, Table 1 of Chapter XVI, is based upon the cost of operations performed by specialists - \$51.38 million, and obstetrical care - \$16 million, a total of \$67.38 million. It was considered that the costs chargeable to Workmen's Compensation cases would be somewhat overbalanced by the cost of minor surgery performed by other than qualified specialists, and by the cost of treatment of fractures, etc., to correspond roughly to the \$72 million figure developed independently.

11/ New York State Insurance Report, Vol. III, 1944.

12/ Estimated from statement of Director of Division of Self-Insurance. Represents 500 private employers and 700 political subdivisions.

13/ See Chapter VIII.

Unpublished data supplied by Dr. Nathan Sinai provided an estimated cost of \$93 million for in-hospital physician service, of which about 80 per cent or \$74.4 million was thought to be attributable to surgery and obstetrics. This amount would be lessened by cases chargeable to Workmen's Compensation, and increased by surgical service to out-of-hospital cases.

The data available from experience under surgical contracts of the voluntary medical insurance plans are not as helpful as they might be, owing to the fact that a maximum is prescribed. However, surgical contracts pay out about \$3.50 per capita,^{8/} which for the State population would be about \$49 million. Obstetrical cases would increase this by about \$16 million to a total of \$64 million.

All available data point to a cost of about \$70 or \$72 million for surgical and obstetrical care.

Cost of in-hospital service. A figure of \$93 million for in-hospital service is estimated from the unpublished data supplied by Dr. Nathan Sinai, which indicated a per capita cost of about \$6.77. No deduction was made from this figure for Workmen's Compensation because a compensating increase in physician service in the hospital would be expected if payment for physician service for out-of-hospital cases were not included in the program.^{14/} This figure was employed in Plans 1 and 2 of Table 1, Chapter XVII.

Home and office service. \$177 million is estimated as the cost of home and office service by physicians, the figure being obtained simply by subtracting \$93 million as the cost of in-hospital services from the total of \$258 million, and arbitrarily adding \$12 million to compensate for an anticipated increase in diagnostic and minor surgical procedures in the office which would otherwise be provided in hospitals.

Cost of complete care for children. An estimate of \$34.7 million was obtained by applying to the cost for each disease category, the ratio of the disease expectancy rates under 8 years of age to the rates for all ages, as given in the Lee-Jones Study.^{5/} Eye refraction was included. This figure was employed in Plans 2, 3, 4 and 6 of Table 1, Chapter XVI. Because children require relatively more physician care than the population as a whole, and because no part of the cost is chargeable to Workmen's Compensation, etc., the per capita cost is about \$24.80, exclusive of refraction, as compared with \$18.76 for the population as a whole. The

^{14/} It is estimated that this figure would cover also prenatal, and obstetrical and surgical after care.

addition of refraction brings the cost to \$25.09

Well-child care under 8 years of age. In estimating a cost of \$10 million, allowance was made for a maximum of 9 visits during the first year of life and 3 annually thereafter for health supervision and immunization.

Eye Refraction

It has been estimated that about 175 eye refractions per 1,000 population per year would be necessary. Assuming that one-half would be done by physicians (ophthalmologists) at \$7.50, and one-half by optometrists at \$4.00, the total annual cost would be \$13.01 million. The per capita cost would be about \$0.95

X-ray

The estimated annual cost of x-ray examination and radiotherapy shown in Table 4 is based on the volume of service required in the Lee-Jones Study^{2/} at Workmen's Compensation rates for physicians with "XD" qualifications (see Table 1), i.e., a physician who "either does not limit his practice to the special field or is not yet authorized to act as consultant in the branch of medicine in which he has been adjudged competent." At these modest rates,^{15/} x-ray and radiotherapy service would cost \$51,383,750 for the State population (including Workmen's Compensation cases).

Table 4. Estimated Cost of X-ray Examinations per 1000 Population at Workmen's Compensation Rates ^{a/}, New York State.

Disease category	Cost of x-ray
Respiratory	\$ 958.75
Digestive	1,374.83
Acute communicable	-
Injuries	194.94
Puerperal	-
Syphilis & gonorrhea	30.10
General diseases	654.30
Skin	7.20
Female genital	254.06
Ear & mastoid	11.89
Muscles, bones, etc.	30.03
Kidneys & annexa	40.21
Heart & arteries	40.53
Eye & annexa	13.96
Circulatory	2.37
Male genital	-
Neuralgia, etc.	78.28
Neurasthenia, etc.	-
Nervous & mental	45.55
Total	\$3,737.00

^{a/}Rates for physicians with "XD" qualifications, see Table 1.

^{15/} Fees for specialists with "SD" qualifications are about 35 to 40 per cent higher.

There is, however, some question as to the desirability of using these figures. Table 5 shows the results of a study of the experience of an average hospital in respect to x-ray costs. The actual cost of providing service under these circumstances was about 38 per cent of that which would be allowed under the "XD" schedule, and about 25 per cent of that which would be allowed under

Table 5. Comparison of Actual Cost of X-ray Diagnostic Examinations in an Average Hospital with Cost That Would Be Incurred if Same Examinations Were Purchased at Rates Prescribed in Minimum Medical Fee Schedule for Workmen's Compensation Cases for Examinations by a Full Specialist ("SD" Qualification), and by a Limited Specialist ("XD" Qualification).

Type of examination (Column)	No. in sample a	"SD" Unit cost b	Cost for sample c	Type of examination (Column)	No. in sample a	"SD" Unit cost b	Cost for sample c
Abdomen.....	35	\$15	\$ 525	Knee.....	38	\$ 8	\$ 304
Ankle.....	28	8	224	Leg.....	19	8	152
Arm.....	10	8	80	Mandible.....	3	10	30
Barium enema.....	83	20	1,660	Mastoid.....	6	15	90
Chest.....	553	15	8,295	Maxilla.....	2	10	20
Chest fluoroscopy.....	14	8	112	Nose.....	1	10	10
Clavicle.....	1	10	10	Pelvis.....	26	15	390
Cystogram.....	1	15	15	Retrograde pyelogram...	21	15	315
Elbow.....	16	8	128	Ribs.....	3	15	45
Femur.....	11	8	88	Shoulder.....	21	10	210
Finger.....	19	5	95	Sinuses.....	22	15	330
Foot.....	19	8	152	Sinus tract...	1	10	10
Gall-bladder.....	32	25	800	Skull.....	45	20	900
Gastrointestinal (upper)....	125	25	3,125	Spine.....	66	15	990
Gastrointestinal (complete).	11	35	385	Teeth.....	37	10	370
Genito-urinary.....	70	15	1,050	Tibia.....	13	8	104
Hand.....	16	8	128	Toe.....	7	5	35
Hip.....	38	15	570	Ventriculogram	5	25	125
Intravenous pyelogram.....	31	25	775	Wrist.....	26	8	208
				Total	1,475		22,855

Note: Column a is result of sampling process, every twelfth examination being tabulated. Column b is unit cost from Workmen's Compensation Fee Schedule. Column c is the product of Columns a and b.

These costs tend to be low because no extra charge was made when fluoroscopy of chest was done in addition to x-ray photography.

Calculations: Records sampled are those for period July 1943 - June 1944, except October 1943. Sample was one-twelfth of total experience.

$$\text{Correction factor} = 12 \times \frac{12}{11} = 13.0909$$

Total cost for sample, \$22,855 x 13.0909 = \$299,193 expected income at Workmen's Compensation "SD" rates, and \$199,462 at "XD" rates (assuming "XD" rates to be two-thirds of "SD" rates).

Actual costs were \$76,336, for salaries, supplies, housing, light and all overhead, for fiscal year ended July 1, 1944. This represents about 25 per cent of "SD" rates and 38 per cent of "XD" rates.

Table 6. Comparison of Actual Cost of Laboratory Service in an Average Hospital with Cost That Would Be Incurred if Same Work were Purchased at Rates Prescribed in Minimum Medical Fee Schedule for Workmen's Compensation Cases.

Type of examination	No. of exams	Unit cost	Total cost	Type of examination	No. of exams	Unit cost	Total cost
Diphtheria culture	4	\$ 2	\$ 8	Stomach contents	65	\$ 5	\$ 325
Typhoid agglutination	58	3	174	Urinalysis	6,537	2	13,074
Salmonella "	42	3	126	Urine culture	285	5	1,425
Proteus X "	6	3	18	" smear	2	3	6
Typhoid culture <u>a/</u>	5	5	25	" chem.exam.	3,639	2	7,278
Dysentery " <u>a/</u>	2	5	10	" phthalein test	53	2	106
Salmonella " <u>a/</u>	1	5	5	" Mosenthal "	35	5	175
Typhoid " <u>b/</u>	1	5	5	" miscellaneous test	8	2	16
Gonorrhea "	17	3	51	Pregnancy test	57	10	570
" smear	24	2	48	Tissue examination	1,358	15	20,370
Malaria	9	2	18	Post-mortem "	81	75	6,075
Meningitis	8	5	40	Autogenous vaccine	23	10	230
Ova & larvae	7	3	21	Blood sugar	1,573	2	3,146
Protozoa	11	3	33	" NPN	1,274	2	2,548
Pneumo. typing	49	5	245	" chlorides	159	3	477
" bl. culture	11	5	55	" carbon dioxide	40	2	80
Strept.throat "	14	3	42	" total prot.	66	3*	198
Syphilis ppt. test	693	3	2,079	" alb./glob. ratio	14	7.50	105
" darkfield	1	5	5	" cholesterol	14	3	42
Tbc. animal test	13	10	130	" sulfonamide	357	3*	1,071
" smears	107	3	321	" amylase	6	3*	18
Undulant fever	39	3	117	" phosphatase acid	49	3*	147
Blood typing	1,330	5	6,650	" " alk.	26	3*	78
" compatibility	721	5	3,605	" VandenBergh	6	3	18
Blood count, complete	4,579	5	22,895	" uric acid	84	3	252
Sedimentation rate	722	3	2,166	" calcium	19	3	57
Coagulation time	565	2	1,130	" phosphorus	4	3	12
Blood culture	282	5	1,410	Urea	6	2	12
Serologic examination	194	3	582	Addis count	2	5*	10
Miscellaneous cultures	756	5	3,780	Urea clearance	1	5*	5
Miscellaneous smears	16	3	48	Liver function	3	5*	15
Feces, chemical	238	5	1,190	Creatinines	5	3	15
Feces, culture	59	5	295	Vitamin C	3	3*	9
Spinal fluid	157	5	785				
Pleural fluid, etc.	50	5	250				
				Total	26,645		\$106,327

a/ Feces or urine

b/ Blood

*Cost estimated; not stated in schedule

Actual cost:

Salaries	\$ 13,825.32
Rent and overhead	7,700.00
Supplies	1,591.60
Repairs and equipment	500.00
Depreciation	500.00
Total	\$ 24,116.92

Actual cost is 22.6 per cent of that which would be allowed at Workmen's Compensation rate.

the "SD" schedule.

Cost for out-of-hospital patients under a comprehensive program.

In these cost estimates it has been assumed that if all physician service was provided in home, office and hospital, about two-thirds of the cost of x-ray examination and treatment would be incurred in hospitals and about one-third in physicians' offices. On this basis, \$15.4 million would be paid to physicians. However, if a lower rate schedule were used, amounting to about two-thirds of the "XD" schedule,^{16/} payments to private physicians would be about \$10 million.

Cost for out-of-hospital patients under a home and office program.

Under programs such as the Plans 2, 3, 4 and 7 shown in Table 1 of Chapter XVI, a larger proportion of x-ray work would probably be done out-of-hospital, at an estimated cost of \$12 million (an addition of \$4 million for laboratory service makes up the \$16 million total for diagnostic x-ray and laboratory service).

Cost for in-hospital patients. Under programs such as the Plans 1 and 5 shown in Table 1 of Chapter XVI, the cost of x-ray service for in-hospital patients would be included in the hospital cost. However, if as in Plan 4, x-ray and laboratory but not other hospital services were covered, about \$12 million would be provided for in-hospital x-ray service.

Cost of out-of-hospital x-ray for children under 8. Children require relatively less x-ray service than adults. On the basis of Lee-Jones expectancy figures it is estimated that in a program such as the Plan 6 shown in Table 1 of Chapter XVI, x-ray service for this group, together with laboratory service, would amount to about \$1 million only.

Laboratory Service

At Workmen's Compensation rates, laboratory service would prove relatively costly. Table 6 shows the experience of an average hospital laboratory to have been that the actual cost was only about 23 per cent of the cost that would be expected if the same services were performed at Workmen's Compensation rates.

In estimating the cost of laboratory service, only examinations such as blood chemistry, basal metabolic rate and electrocardiogram were included, it being expected that most of the cultural and serologic tests, etc.,

^{16/} At "XD" rates, x-ray of chest is \$11, gastro-intestinal series is \$25. At the rates employed here, the respective fees would be \$7.33 and \$16.70. Unpublished data indicate that the latter figures are nearly twice the actual cost of these services when provided by hospitals employing radiologists on a salary.

would be done in public health or hospital laboratories. On this basis, \$4 million was allowed for laboratory service for out-of-hospital patients (\$1.5 million for physicians and \$2.5 million for laboratories) and \$6.5 million for in-hospital patients.

Physiotherapy

The cost of physiotherapy was estimated as shown in Table 7, on the basis of Workmen's Compensation rates. This service would cost \$2.33 mil-

Table 7. Estimated Cost of Physiotherapy per 1000 Population at Workmen's Compensation Rates,^a/New York State

Disease category	Physiotherapy
Respiratory	\$ -
Digestive	0.65
Acute communicable	-
Injuries	383.38
Puerperal	-
Syphilis & gonorrhea	-
General diseases	1.28
Skin	25.58
Female genital	-
Ear & mastoid	8.75
Muscles, bones, etc.	-
Kidneys & annexa	-
Heart & arteries	-
Eye & annexa	-
Circulatory	-
Male genital	-
Neuralgia, etc.	-
Neurasthenia, etc.	-
Nervous & mental	-
Total	\$419.64

^a/ See Table 1.

lion for the State's population. Of this sum, it is estimated that \$0.8 million might be payable to physicians, \$0.5 to registered physiotherapists, and the remainder to hospitals.

Visiting Nurse Service

This figure is based upon the assumption that one generalized public health nurse per 2,000 of population can provide all necessary visiting nurse care, and that in the course of a year she would make 200 home visits in which actual nursing skill would be applied. The total of 1.33 million visits thus calculated would cost \$2.0 million per year if purchased at a rate of \$1.50 each.^{17/} This is perhaps an under-

estimate in view of the fact that in 1944, public health and other visiting nurses made about 1.1 million bedside visits.

In addition, \$0.4 million has been allowed for emergency nursing care in the home.

Dental Service

The great frequency of dental disease combined with the facts that little may be expected of nature in the way of restoration of dental tissue destroyed by disease, and that artificial repair is very time-consuming, makes the cost of adequate dental service very high. Adequate care

^{17/} In 1944 the average cost per visit to the Metropolitan Life Insurance Company was \$1.42 for service purchased from visiting nurse associations.

of one small portion of the body - the teeth and gums - is as costly as the care of all of the remainder of the body.

Partly because of the great expense of dental care, and partly because it does not cause marked disability, over a period of years there has accumulated a great reservoir of dental defects. The cost of service developed here does not cover the correction of accumulated dental defects, but deals only with the treatment of the average incidence of dental disease and the current provision of prophylactic dental service.

Because it would obviously not be feasible to furnish persons of all ages with adequate dental service, cost estimates have been made for various age groups - in detail for the group under 18 years and roughly for the older groups - and for certain types of service, such as extractions, which might be feasible of inclusion in a general medical care program.

The volume of service required for adequate dental care has been taken from the Lee-Jones Study,^{5/} and includes semi-annual oral prophylaxis, x-ray, fillings, extractions, crowding, bridges and dentures, and treatment of gum conditions. The charges of dentists are extremely variable,

Table 8. Data Employed in Developing Fee Schedule for Care for Children Under 18

Service a/	Hours	Cost at \$7.00 per hour	Twice welfare fee	Fee selected
Prophylaxis (including simple fillings, children 3-4)	.75	\$ 5.25	\$ 4.00	\$ 4.00
Prophylaxis (other ages)	.50	3.50	4.00	4.00
Temporary fillings - temporary teeth	.33	2.30	1.00	2.00
Silver amalgam, permanent teeth - one surface	.75	5.25	4.00	4.00
Silver amalgam, permanent teeth - two surfaces	1.00	7.00	6.00	6.00
Silicious cement fillings (front teeth)	.75	5.25	6.00	6.00
Extract deciduous teeth	.42	3.00	2.50	2.50
" impacted or submerged teeth	1.10	7.50	10.00	7.50
Gum treatments	.42	3.00	2.00	2.00
Full-mouth x-ray	.58	4.10	6.00	5.00
Partial x-ray	.16	1.10	1.00	1.00
Orthodontia, extensive (3 years)	44.0	352. b/	-	350.00
" moderate (3 years)	11.0	88. b/	-	85.00
" moderate (4 months)	10.0	80. b/	-	85.00

a/ Fees cover supplies in all services except orthodontia, and include necessary post-operative visits. Orthodontia includes laboratory hours of dentist, but not costly materials.

b/ Cost computed at \$8.00 per hour.

more so than those of physicians, in respect to both fees and hourly rates.^{18/} In the absence of an official fee schedule which might be employed under an insurance program, there was developed a working schedule based upon (a) twice the fees allowed under the public welfare medical care program,^{19/} and (b) an hourly rate of \$7.00,^{20/21/} the lower or more reasonable fee being selected. The fee schedule, which is shown in Table 8, was employed only for children under 18 and for extractions at all ages, the costs for other age groups being calculated at an hourly rate of \$7.00

Complete care, children under 18. In Table 9 there is shown the type of service, units of service needed per child, unit cost and case cost for each service. The latter figure is applied to the number of persons in the specified age group according to the 1940 census, to give the total cost for the State.

Table 9. Estimated Cost of Complete Dental Care, Children Under 18

Type of service	Units of service	Unit cost	Case cost	Millions of persons	Millions of dollars
Children aged 3-4					
Prophylaxis, including simple fillings	2.2	\$4.00	\$8.80		
Fill temporary teeth	.3	2.00	.60		
Extract " "	.1	2.50	.25		
Full x-ray	.1	5.00	.50		
Partial x-ray	.2	1.00	.20		
Total			10.35	.340	\$ 3.519
Children aged 5-17					
Prophylaxis	2.0	\$4.00	\$8.00		
Fill temporary teeth	.3	2.00	.60		
Silver fillings, one surface	1.4	4.00	5.60		
" " , two surfaces	.1	6.00	.60		
Extract temporary teeth	.6	2.50	1.50		
" impacted teeth, etc.	.05	7.50	.38		
Gum treatments	1.1	2.00	2.20		
Orthodontia, extensive	.02	350.00	7.00		
" , moderate	.03	85.00	2.55		
Full x-ray	.5	5.00	2.50		
Partial x-ray	.65	1.00	.65		
Total			31.58	2.924	\$92.340

Complete dental care, persons 18 and over. In Table 10 there is shown the cost of complete dental care for persons 18 years of age and over, calculated at a rate of \$7.00 per chair or laboratory hour for the 18/ A Study of Physicians and Dentists in Detroit: 1929, N. Sinai and A. B. Mills, Publication No. 10 of the Committee on the Costs of Medical Care.

19/ Manual of Medical Care, New York State Temporary Emergency Relief Administration, March 1935.

20/ For a productive working year of 1,500 hours, this would provide an average income of \$10,500 gross and \$6,100 net.

21/ \$8.00 per hour allowed for the specialty of orthodontia.

dentist, and \$5.00 for complete and \$1.00 for partial x-ray examinations. This simple method of calculation yields figures closely approximating those which would be obtained if the fees shown in Table 8 were employed.

Table 10. Estimated Cost of Complete Dental Care, Persons 18 and Over

Service	Hours	Exams	Rate	Cost per person	Millions of persons	Millions of dollars
Age 18-44						
General practitioner	3.30		\$7.00	\$23.10		
Exodontist	.22		7.00	1.54		
Full x-ray		1.0	5.00	5.00		
Partial x-ray		1.2	1.00	1.20		
Total				30.84	6.12	\$188.74
Age 45 and over						
General practitioner	3.08		\$7.00	\$21.56		
Exodontist	.24		7.00	1.68		
Full x-ray		.75	5.00	3.75		
Partial x-ray		.72	1.00	.72		
Total				27.71	3.92	\$108.62

Emergency dental care, persons 18 and over. Table 11 shows the cost of emergency dental care (extractions, gum treatments, and partial x-rays before and after extraction) for persons 18 years of age and over, computed by the method employed for Table 9.

Table 11. Estimated Cost of Emergency Dental Care, Persons 18 and Over

Type of service	Units of service	Unit cost	Case cost	Millions of persons	Millions of dollars
Age 18-44					
Extraction, simple	.50	\$2.50	\$1.25		
" , impacted	.10	7.50	.75		
Gum treatments	.80	2.00	1.60		
Partial x-ray	1.20	1.00	1.20		
Total			4.80	6.12	\$29.38
Age 45 & over					
Extraction, simple	.30	\$2.50	\$.75		
" , impacted	.06	7.50	.45		
Gum treatments	1.70	2.00	3.40		
Partial x-ray	.75	1.00	.75		
Total			5.35	3.92	\$20.97

Total cost of adequate dental care. Table 12 summarizes the cost figures for all age groups. The cost of adequate dental care (exclusive of materials for dentures) is estimated at \$393 million annually, almost as much as is needed for adequate hospital and physician service for all persons. Although some reduction might be brought about by a reduction

Table 12. Cost of Adequate Dental Care,
New York State (Millions)

Age group	Dentist	X-ray	Total
3-4	\$ 3.281	\$.238	\$ 3.519
5-17	83.129	9.211	92.340
18-44	150.797	37.944	188.741
45 & over	91.101	17.522	108.623
Total	328.308	54.915	393.223

in fees or services (e.g., limiting prophylaxis to once a year), the resultant sum would still be very large. It has been recommended that the best method of approach

to this problem is to begin with young children, e.g., those under 8 years of age. The cost of such a program during the first year of operation would be about \$9 million, estimating from an annual per capita cost of \$10 for the children 3 to 5 years of age. The following year, service might be provided to the group which had attained 9 years of age. The original group could be carried through successive years up to any desired limit. New children would be added as they attained 3 years of age. The annual per capita cost would undoubtedly increase as the program was thus extended beyond 8 years of age,^{22/} but by this method of gradual expansion a program might be developed progressively at a reasonable cost.

Hospital Service

The estimate of \$107.6 million employed in Plans 1, 2, 3 and 5 of Table 1, Chapter XVI, covers basic hospital service, i.e., bed and board, x-ray, anesthesia, laboratory service, etc., but not the additional cost of private or semi-private accommodations. It is based on the expectation that the 13.75 million residents of the State would require 19 million days of hospital care, inclusive of Workmen's Compensation cases.

The per diem cost is based on 1942 data reported to the State Department of Social Welfare for all hospitals, private and public. For the private hospitals, a per diem rate amounting to 85 per cent^{23/} of total cost (including private and semi-private room, and out-patient department cost) was utilized as representing the cost of basic service; i.e., the cost of accommodations in multiple-bed rooms. For the public hospitals, the actual costs (including out-patient department cost) were utilized. The data employed, and the rates for various types of hospitals, are shown in Table 13. At a rate of \$6.21 per day, the 19 million days care anticipated under an insurance program would cost \$117.6 million. From this there was deducted \$10 million as the approximate amount receivable for Workmen's Compensation cases (see Chapter VIII), leaving \$107.6 million, or \$7.83 per capita, as^{22/} The per capita cost for children 5-17 years is over \$30, but for children aged 5, 6 and 7 only, it would probably not greatly exceed the \$10 figure for children 3-4 years.

^{23/} In reality, this is about 93 per cent of cost of in-patient service because, as shown in Table 14 of Chapter XIV, out patient-costs for private hospitals represent about 7.8 per cent of total cost.

the amount that would be payable under an insurance plan. Because adequate data have not been available for estimating current costs, the figures cited have been employed. However, from a comparison of the \$6.71 rate for private general hospitals in 1942 (Table 13), and the \$7.37 rate shown in Table 14 of Chapter XIV for private general hospitals in 1945 (the latter being gross in-patient cost), it appears that an increase of about 10 per cent might be necessitated.

As shown in Table 8 of Chapter XIV, 94 per cent of the private general hospital beds include x-ray, and 89 per cent include laboratory service as a part of the hospital service for such beds. The respective percentages would probably be higher in the public hospitals. Hospital service

Table 13. Calculation of Per Diem Cost of Basic Hospital Service, New York State, 1942-43^{a/}

Type of hospital	Days care <u>b/</u>	Total costs <u>c/</u>		Adjusted costs <u>c/d/</u>	
		Amount	Per diem	Amount	Per diem
General					
Public	5,106,350	\$ 29,055,131	\$5.69	\$ 29,055,131	5.69
Private	10,612,375	83,731,539	7.89	71,171,393	6.71
Orthopedic					
Public	44,165	195,534	4.45	195,534	4.45
Private	394,200	2,475,576	6.28	2,104,240	5.34
Contagious					
Public	250,755	1,495,425	5.96	1,495,425	5.96
Other special					
Public	137,970	378,038	2.74	378,038	2.74
Private	1,408,570	8,296,477	5.89	7,052,005	5.01
All types					
Public	5,539,240	31,125,128	5.62	31,125,128	5.62
Private	12,415,145	94,503,692	7.61	80,328,138	6.20
Total	17,954,385	125,628,820	7.00	111,453,266	6.21

a/ Exclusive of tuberculosis and mental hospitals and departments of institutions.

b/ From "Hospital Service in the United States", Journal of the American Medical Association, 124:839, March 25, 1944.

c/ Rates include cost of care for new-born infants for an average period of 10 days at a cost one-fourth of that for adults. Out-patient department costs are included.

d/ Adjusted on basis of 85 per cent of total, for private hospitals.

at these rates would thus include x-ray and laboratory service in nearly all instances. Social service would cover about 60 per cent of the bed capacity of private hospitals. Data on anesthesia and physiotherapy are lacking. It is believed that a majority of hospitals include drugs and dressings in their cost figures. As a rule, only general duty nursing is included, except for very ill patients. The estimated cost of hospital service would therefore include bed and board, all nursing service required by the medical needs of the patient, and necessary drugs and dressings in

all instances; and x-ray, laboratory service, anesthesia, physiotherapy and social service in a majority of instances.

CHAPTER XXI

PROVISION OF BENEFITS

This chapter is concerned with the eligibility of professional practitioners, hospitals, etc., to participate in a medical insurance plan, and the methods which might be employed for their remuneration. Table 4 of Chapter XV illustrates the methods employed by national health insurance plans in providing and paying for medical practitioner benefits. Fee-for-service, capitation and salaried practice are all employed, often in combination.

Participating Physicians and Dentists

The advantages of limiting participation to physicians and dentists named by the insuring agency seem to be that through selection of practitioners of a competence demonstrably above average, and through controls that may be exerted over them, it is possible to assure the delivery of care of high quality. The degree to which this objective may be realized depends, of course, in large part on the financial and other attractions that the insuring agency can offer to participating practitioners. A further advantage may be that the conditions of practice may be so arranged or controlled as to effect economies in expenditures without sacrifice of quality of service. A large proportion of consumer-sponsored insurance plans, and many industrial plans, provide service only through practitioners on a staff or panel which the insuring agency has selected.

A few industrial or consumer-sponsored plans, practically all other voluntary plans, and a great majority of the State and national compulsory plans which have been proposed, permit any licensed physician (or dentist) to participate. If practitioners are paid on a controlled basis, e.g., salary or capitation, the patient is afforded his choice within these limits. In a system which is open to all practitioners, a distinction is almost always made between specialists and general practitioners. However, this is usually for purposes of remuneration, rather than for limiting the provision of special services to those who qualify as specialists. Non-specialists are ordinarily permitted to provide special services at a reduced rate. A further distinction is sometimes made between participating and non-participating practitioners, the former being paid on the basis of a higher fee schedule but being subject to pro-rating of payments if the income of the insuring agency does not meet expenses.

Whatever system of remuneration may be employed, the State should not

attempt to dictate the choice of practitioner. Remedies for deficiencies in the quality of care should be sought, not in the insurance law or regulations, but in basic State laws relating to professional education and licensure, and through the provision of opportunities for post-graduate education. However, because the professional education laws do not cover the qualification of specialists, this function is a proper duty of the insuring agency, although it may rely on the advice of non-official professional boards. A distinction between "participating" and "non-participating" practitioners would not seem necessary in view of the fact that it would be the beneficiaries rather than the participating practitioners who would underwrite the financing of a compulsory plan.

Participation in a State plan would thus be open to any person licensed to practice medicine or dentistry in the State (or any approved medical or dental group as described in a subsequent section) within the limits of his professional competence as defined by the State Education Law and as qualified by the insurance agency in respect to specialist services. In an emergency, care given outside of the State by a practitioner qualified under the laws of the State in which such care was rendered, or care given in this State by a medical practitioner qualified under the laws of another State might be paid for if the insuring agency were satisfied as to the need for such care.

Medical and Dental Groups^{1/}

A strong interest in the group practice of medicine is evident in many quarters. The primary advantage of group practice seems to be an improvement in medical care through the provision of service by well-balanced, intimately associated groups of physicians so organized and coordinated with regard to the special aspects of practice as to deal with the patient in comprehensive fashion. Further, the association of physicians in a group provides stimulating professional contacts and opportunities for organized post-graduate education, and tends to make the members of the group alert and well-prepared for the inevitable review of their work by their colleagues.

The proponents of group practice assert that when medical practice is not organized, the patient requiring the services of more than one physician is apt to suffer from lack of continuity and integration of service, that consultants may not be employed as frequently as necessary

^{1/} Although this section was prepared with only medical groups in mind, it applies generally to dental groups, as well.

and as would be the case with a group, and that physicians practicing individually often fail to maintain or improve their skill owing to a lack of close association with other physicians.

Secondarily, group practice may bring about some decrease in the costs of medical care through decreasing overhead expense and making more efficient use of the physician's time.^{2/} Also, the physician may be relieved of many non-professional duties.

Relationship to medical insurance. Neglecting all other considerations, group practice seems to be most necessary if good medical teaching is to be carried on under an insurance program which covers all or a large part of the population. With some exceptions, the patients now used for clinical instruction of medical students, internes, residents and other graduate physicians, are the so-called "staff patients." This means that they are not the private patients of individual physicians, but are cared for by the hospital staff in general - internes, residents, attending physicians, instructors, professors, etc.

Under an insurance program whereby fees are available to physicians for every patient, all patients become private patients and do not bear the same relationship to students and graduate physicians as do staff patients. Even under the Blue Cross hospitalization insurance plans, covering 25 per cent or less of the State's population, a dearth of material for clinical instruction is developing. Largely for this reason, and in anticipation of a much greater development of hospitalization and medical care insurance, most of the teaching hospitals in the East have under consideration plans for forming medical groups.

A patient coming under the care of a group is ordinarily permitted to choose his own physician, within certain limits imposed by the group. Because he is paying the group for service, either directly or through his insurance organization, he enjoys to a great extent the status of a private patient, while benefiting from the services of other members of the group. The medical group is or should be so organized that the patient, or the experience gained by an individual physician in caring for the patient, is made available for the instruction of students, internes, residents and full-fledged members of the group.

Group organization and incorporation. Group practice may be organized in varying degrees. In hospitals which do not accept ward or "staff" patients, and in respect to private patients in hospitals which do, the mere selection and organization of physicians into a staff constitutes a simple
^{2/} Health Insurance, Louis Reed, 1937.

type of group and provides some of the advantages of group practice. However, this simple type of group usually does not deal with the economic aspects of practice; each service must be paid for as such by the patient, and for this reason full and efficient use may not be made of available consultants and diagnostic facilities.

Ward or "staff" care of patients is really group practice. In this case, payment by or on behalf of the patient is made to the hospital rather than to the physician (although it usually covers only the cost of hospitalization). The staff physicians receive their compensation not from the patient, but from the hospital. Because little or nothing is paid by the patient for professional services, the compensation of the physician is very modest and may consist only of prestige, privileges, opportunities for training and experience, or payment for teaching.

When fully developed, group practice is provided through a group of physicians organized to render service in accordance with the patient's needs, payment being made by the patient to the group for the diagnosis and treatment of disease rather than for the services of individual practitioners. Payment may be made by the patient as need for medical service arises, or in advance on a pre-payment or capitation basis. Within the group, physicians may be compensated on a salary basis, a division of net proceeds, or some other mutually satisfactory arrangement.

Because the growth of hospital and medical insurance has stressed a need for group practice which would be intensified by a compulsory insurance program, and in the interest of improving the quality of medical care, a study of group practice was undertaken. The legality of a limited type of group such as a hospital staff is not open to question. There is, however, a real question as to whether and under what conditions physicians may practice as a group, rendering services and making charges as a group rather than as individuals. In an attempt to clarify this point the literature on the subject was consulted and advice was obtained from the Attorney-General, and the Solicitor-General of New York State, and from a consultant attorney.

Practice of medicine by hospital or similar corporation. With one very important exception, which follows, the courts have held that the right to practice the learned professions (medicine, law, dentistry, etc.) is:

a personal right, limited to a few persons of good moral character, with special qualifications ascertained and certified after a long course of study, both general and professional, and a thorough

examination by a state board appointed for the purpose.^{3/4/}

The courts have, however, looked with a realistic eye at the necessities of medical practice and have sanctioned the practice of medicine by corporations such as hospitals and dispensaries. Relative to this practice, the Court of Appeals stated (People v. Woodbury Dermatological Institute, 192 N.Y. 454):

The only difficulty involved in the adoption of this view [the contention of the lower court that a corporation may not legally practice medicine] grows out of the existence of hospitals, dispensaries and similar corporate institutions which are unquestionably authorized by law to practice medicine - although of course only through the agency of natural persons who are duly registered as physicians.^{2/}

The Court then went on to state:

It seems to me, however, that we can affirm this judgment without in any wise denying the lawful right of hospitals, dispensaries and similar corporate institutions to advertise their readiness to exercise their lawful functions; and this simply for the reason that the general medical law of 1907 is obviously not intended to apply to the case of such corporations at all. In other words, the prohibitions therein contained against the practice of medicine without lawful registration in this state or in violation of any of the provisions of the statute or against advertising by any person not a registered physician were not intended to apply and plainly could not reasonably be held to apply to corporate bodies which by the express provision of other statutes are authorized to carry on the practice of medicine upon compliance with their provisions and without registration. The incorporation of hospitals is provided for in Section 80 of the Membership Corporations Law as amended by Chapter 404 of the Laws of 1900.

The law referred to provided that five or more persons might become a corporation for the purpose of erecting, establishing or maintaining a hospital, infirmary, dispensary or home for invalids, aged or indigent persons by making a prescribed certificate and obtaining the written approval of the State Board of Charities and a justice of the Supreme Court.

The statute expressly provided that the systems of medical practice or ^{3/} Quoted from opinion of the Court of Appeals relative to practice of law by a corporation, Matter of Cooperative Law Company, 198 N.Y. 479.

^{4/} It should be noted in passing that this ruling applies only to the direct practice of medicine, and not to group health or medical insurance organizations as usually constituted. In exempting a group health plan from the charge of violating the licensure act, the court ruled: "It is true that a corporation can act only through its agents and employees, but the physicians with whom the plaintiff (Group Health Association) makes contracts are rather in the position of independent contractors, and the plaintiff does not in any way undertake to control the manner in which they attend or prescribe for their patients." Group Health Assoc. v. Moor 24 F. Supp. 445 (DDC 1938).

^{5/} In a later case it was stated that "a hospital undertakes not to heal or attempt to heal through the agency of others, but merely to supply others who will heal or attempt to heal on their own responsibility." Matter of Bernstein v. Beth Israel Hospital, 236 N.Y. 268, 270.

treatment to be used or applied in such hospital, infirmary, dispensary or home might be specified in the certificate. Thus, it was stated that a hospital duly incorporated under the Membership Corporations Law unquestionably held itself out as being able to diagnose, treat, operate and prescribe for human disease, pain, injury, deformity or physical condition; and that an institution of that character, possessing legislative authority to practice medicine by means of its staff of registered physicians and surgeons, came under the direct sanction of the law in doing.

Practice of medicine by a group of physicians. According to Mr.

Wilcox:

While the same arguments which justify the apparent practice of medicine by hospitals might be used to justify the practice of medicine by the physician membership of a membership corporation, we believe statutory enactment would be necessary to legalize such an endeavor. A membership of stock corporation might be formed to take ownership of necessary equipment and apparatus, but the actual furnishing of medical care under present statutes must, we believe, be furnished by the individual physician. There is, however, no legal reason why a group of physicians may not form a partnership for the group practice of medicine just as the practice of law is carried on by law firms, which are partnerships. Ownership of professional instruments and apparatus could be vested in the partnership and the expenses and income of the partnership pro-rated among the partners according to agreed percentages. 6/

Corporate group practice. It seems clear that a group of physicians may lawfully practice medicine as a partnership. This type of organization would be unwieldy, however, in the case of a hospital staff, where a considerable turnover in personnel would be expected and where there would have to be frequent re-calculation of the percentage of total income to which each partner would be entitled.

It would also be lawful for a hospital or dispensary to practice medicine as a corporation. It thus seemed that it would not be contrary to public policy for physicians to practice as a group if safeguards were provided against the abuses which might arise if lay corporations were permitted to practice medicine for gain.

To remove any lingering doubt as to the legality of corporate group practice under proper conditions, and to provide an incentive for its development, it was thought there should be included in any law governing a medical insurance plan a section somewhat as follows:

Notwithstanding the provisions of any general or special law, the governing board, or any group of medical practitioners who constitute

6/ Letter dated August 10, 1945 from Charles S. Wilcox, Law Offices of Harris, Beach, Keating, Wilcox and Dale, 5 South Fitzhugh Street, Rochester 4, New York.

the staff of any non-profit hospital or dispensary incorporated under the laws of this state or any municipally owned or operated hospital or dispensary, may apply to the state commission on medical care for approval to incorporate under the membership corporations law as an approved medical group for the purpose of furnishing medical service under this act and other types of service specifically approved. Upon satisfying itself of the competence of the applicant and that the purpose for which incorporation is desired is in the public interest, the commission shall issue a certificate of approval. The service to be furnished by such group shall be stated in the articles of incorporation and may comprise either medical service in the hospital, in the hospital out-patient department or dispensary, in the home, or any combination thereof. Such group shall have the right to employ such physicians, dentists, nurses, optometrists, physiotherapists, technicians, clerical and other personnel as may be necessary to its work. Professional services furnished by such group shall be rendered under the responsible supervision of practitioners qualified by the state education law and such practitioners shall be individually and severally liable for the propriety and quality of the care furnished.

The effect of the proposed section would be simply to permit the economic aspects of medical practice to be included in the type of group practice now exemplified by hospital staffs. No profit would be gained by the corporation. The requirement that the group adhere to some non-profit institution would provide a guarantee of facilities and quality of service and, in the case of incorporation by a governing board, public representation. Physicians wishing to practice as a group apart from a non-profit institution might do so in partnerships.

The Attorney-General's office and Mr. Wilcox were asked to comment on the proposed legislation. Mr. Wilcox replied as follows:

The proposed legislation,...seems to adequately cover the case of a group of physicians, connected with a hospital staff, who may wish to incorporate for purpose of practicing as a group in connection with hospital work. I am wondering whether, as a practical matter, the proposal of such legislation might not arouse considerable opposition by practicing physicians at large who might take the position that if group practice in corporate form is to be legalized, the privilege should be available to groups of private practitioners as well as groups connected with hospital staffs.

The proposed legislation does not make it clear how charges for professional services are to be billed. Is it contemplated that the membership group would render bills for the services of its professional membership, and if so, (since the membership corporation is a non-profit organization), who are to be the ultimate recipients of fees collected? Or is it contemplated that the hospital will include in its bill any charge for professional services and the professional activities of the membership of the corporation will be reflected in the salaries paid them by the hospital? I think it might be well to give some thought to clarifying these matters in the proposed legislation.

Solicitor-General Judd wrote that the subject matter was not appropri-

ate for an opinion of the Attorney-General because the matter seemed to lie within the power of the Legislature. Mr. Judd's personal suggestions were as follows:

Your question is, whether the proposed legislation is consistent with public policy and whether it will probably be upheld by the courts.

The legislation appears to lie within the power of the Legislature, but whether it is in accordance with public policy is a question on which this office cannot very well advise you.

I might point out that physicians have protested against the dictum in People v. Woodbury Dermatological Institute (192 N.Y. 454, 456) that incorporated hospitals are authorized to practice medicine, and it is doubtful whether such general authority exists under the present provisions of the Education Law, which I previously quoted to you.^{7/}

Another matter to be considered is the general policy against authorizing membership corporations to conduct business for profit. If your proposal is that the staff of a hospital may incorporate to render medical service for a money consideration, it does not seem to me that you can refer to the corporation as a non-profit organization. I would expect that the Legislature, if a bill is submitted to it, would want some definite reasons why you consider that group medical practice should be performed through a corporation, instead of through a partnership. Lawyers have found the partnership method adequate for their professional practice, in spite of many of the same problems which you mention in connection with group medicine.

Before presenting any legislation for action, I would suggest that you have its form carefully considered either by an attorney for the Commission or by the State Bill Drafting Commission.

Shortly thereafter, the Attorney-General rendered an opinion which strengthened the belief that it would not be practicable for a large group such as a hospital staff to practice as a partnership, nor would partnership practice meet the needs of the teaching institutions. The summarized opinion is as follows:

EDUCATION LAW Sec. 1264 (2-f); INSURANCE LAW ART. IX-C

If a contract entered into between a cooperative and a partnership composed of doctors, for the purpose of providing group medical services for the cooperative's members, involves fee splitting by or between the doctors, it is forbidden by L. 1944, c. 466.

Attorney-General Goldstein's complete opinion as set forth in a letter dated October 2, 1945 addressed to counsel for the State Department of Education, follows:

Your letter of September 14 requests my opinion whether Education Law Sec. 1264 (2-f) as amended by L. 1944, c. 466 forbids payment for medical services to a partnership composed of physicians. The specific case suggested is that of a non-profit co-operative cor-

^{7/} Previously, Mr. Judd had referred to Section 1262 of the State Education Law: "1. This article shall not be construed to affect or prevent the following:.... (2) the practice of medicine in a legally incorporated hospital by a physician duly appointed as a member of the resident staff or by an intern...."

poration formed under Article IX-C of the Insurance Law, furnishing medical expense indemnity service to several thousand citizens of this State. It desires to contract on behalf of its members with doctors who will themselves finance the equipment and services involved. Because of the substantial cost of diagnostic and other equipment, and the volume and variety of services involved, there will be advantages in a contract with a partnership if there is no legal barrier to such an organization.

At this point it is necessary to consider the language and history of the statute previously mentioned. Subdivision (f) of Education Law Sec. 1264 was added by L. 1944, c. 466, and added to the grounds of professional discipline previously authorized the following:

(f) That a physician has directly or indirectly requested, received or participated in the division, transference, assignment, rebate, splitting or refunding of a fee for, or has directly or indirectly requested, received or profited by means of a credit or other valuable consideration as a commission, discount or gratuity in connection with the furnishing of medical, surgical or dental care, diagnosis or treatment or service, including x-ray examination and treatment, or for or in connection with the sale, rental, supplying or furnishing of clinical laboratory services or supplies, x-ray laboratory services or supplies, physiotherapy or other therapeutic service or equipment, artificial limbs, teeth or eyes, orthopedic or surgical appliances or supplies, optical appliances, supplies or equipment, devices for aid of hearing, drugs, medication or medical supplies or any other goods, services or supplies prescribed for medical diagnosis, care or treatment under this chapter, except payment, not to exceed thirty-three and one-third per centum of any fee received for x-ray examination, diagnosis or treatment, to any hospital furnishing facilities for such examination, diagnosis or treatment.

The amendment was made as a result of the Moreland Commission investigation of Workmen's Compensation. An illustration of the professional abuses involved is presented by Matter of Sacharoff v. Corsi, 294 N.Y. 305.

It will be noted that the statutory provision is couched in very broad and far-reaching language, and the abuses to which it was addressed were such that it may have been thought they could not have been eliminated by a narrower provision. The possibility brought within this sweeping prohibition is strongly suggested, particularly by the final language excepting, within a percentage limitation, certain payments to hospitals.

Accordingly, I am of opinion that if the proposed arrangement involves any factor of fee splitting it is forbidden by the statute. If the arrangement is limited to securing to each member of the group payment for services performed by him, after contributing a proportion of office expenses approximately equivalent to his use of office facilities, I am of opinion that it is permitted.

It appears that the Medical Society of the State of New York considered the statute cited to be unworkable, and has recommended that the law, where it relates to specialists and non-profit hospitals, be amended as follows:^{8/}

8/ "Minutes of the Annual Meeting, House of Delegates, Medical Society of State of New York," New York State Journal of Medicine, 46:197, January 15, 1946.

except that mutually agreed reasonable and equitable division of any fee received under this chapter for x-ray examination, diagnosis, or treatment, physiotherapeutic examination or treatment, pathologic examination or diagnosis, or administration of anesthesia, may be made by a physician duly authorized to render such services, and a non-profit hospital furnishing facilities for such examination, diagnosis, treatment, or administration.

The proposed legislation governing group practice was revised in accordance with these opinions, and suggestions received from persons and organizations intimately concerned with the necessity for group practice. The provision that groups must be an integral part of non-profit hospitals and dispensaries was maintained, because it was thought that the legal sanction of partnership practice would suffice for smaller groups. The necessity for providing complete service to persons enrolled on a capitation basis was placed in the proposed legislation, in connection with specific sanction of the capitation system of payment which many students of this subject believe to be necessary to assure economy and efficiency of operation, and to afford patients a wide range of benefits.

Physicians seem to believe that only physicians should be permitted to form medical groups, whereas hospital representatives seem to believe that only hospital boards should be permitted to form groups. There are undoubtedly situations where it would be more desirable for the one than for the other to act in this respect; therefore, the proposed legislation would sanction either arrangement to permit the necessary flexibility.

The revised proposal follows:

Notwithstanding the provisions of any general or special law, the governing board of any non-profit hospital or dispensary incorporated under the laws of this State or any hospital or dispensary owned or operated by this State or a political subdivision thereof, or a group of physicians who constitute the duly appointed staff and who act with the explicit approval of the governing board or the person or agency performing the functions of a governing board may apply to the State commission on medical care for approval to incorporate under the membership corporations law as an approved medical group whose purpose it shall be to furnish facilities and persons qualified and authorized by law to render medical care.

The articles of incorporation shall stipulate that any excess of income over expenses after the establishment of a reserve fund of not to exceed fifteen per cent of the average annual income over a period of the three most recent years shall be devoted entirely to a reduction in fees or charges, or to providing medical benefits in addition to those required by the fees or charges payable under this chapter or to research and investigation in the medical sciences.

The service to be furnished by such group shall be stated in the articles of incorporation and may comprise either medical and related service in the hospital, in the hospital out-patient department or dispensary, in the home, or any combination thereof. The articles of incorporation shall state the method or methods of making charges

to be employed, which may be either the fee-for-service method of charging specific fees for specific services, appliances and supplies, or the capitation method of charging an annual fee covering all specified services, appliances and supplies that may be required by an individual or family during such annual period, or a combination of the two methods. Upon satisfying itself of the competence of the applicant and that the purpose for which incorporation is desired is in the public interest, the commission shall issue a certificate of approval. An approved medical group shall have the right to employ such physicians, dentists, nurses, pharmacists, optometrists, physiotherapists, dental hygienists, technicians, clerical and other personnel as may be necessary to its work. Professional services furnished in the name of such approved medical group shall be rendered by or under the responsible supervision of persons qualified by the State education law and such persons shall be individually and severally responsible for the propriety and quality of the services furnished. Charges for service shall be rendered in the name of and shall be payable to the approved medical group.

A medical group enrolling beneficiaries upon a capitation basis shall conform to the following conditions,

1. Enrollment shall include all beneficiaries in a family, a family for the purposes of this section being defined as a single person eighteen years of age or over without dependents under eighteen years of age who are domiciled with him, or a single person eighteen years of age or over with dependents under eighteen years of age who are domiciled with him, or a husband or wife and spouse and dependents under eighteen years of age who are domiciled with them.

2. The minimum period of enrollment shall be six months.

3. The approved medical group shall contract with the beneficiary to furnish all medical service benefits, diagnostic x-ray and radiotherapy service benefits and clinical laboratory service benefits required by this chapter and may but need not contract to furnish dental service benefits, visiting nurse service benefits, hospital service benefits and other benefits not required by this chapter. In the case of an approved medical service group being unable to furnish the benefits contracted for by reason of lack of suitable facilities or personnel, or in the case of emergency care required by a beneficiary during temporary absence from his usual place of residence or for other sufficient reason, such group shall be responsible for the payment of reasonable charges for such services as they may necessarily be provided by other than members of the group.

Diagnostic X-ray and Radiotherapy Service

These services ordinarily require specially qualified personnel and, in general, should be furnished only by or under the responsible supervision of a physician qualified as a roentgenologist. However, certain simple x-ray examinations, such as those incidental to diagnosis and treatment of fractured extremities, etc., and dental x-ray examinations, should be allowed as benefits if provided by any licensed physician or dentist. Also, in an emergency, x-ray examination made by other than a qualified roentgenologist should be allowed.

In some circumstances, such as the treatment of skin diseases, super-

ficial radiotherapy by a dermatologist might be permitted.

Clinical Laboratory Examination

New York State has an extensive system of public laboratories for the diagnosis of communicable and related diseases (see Chapter V) which is supplemented by services supplied by approved hospital laboratories as a part of hospital service. The limited laboratory benefits recommended outside of hospital service (electrocardiogram, blood chemistry, etc.) are not ordinarily furnished by public laboratories. Any physician qualified as a specialist by the insuring agency, or any laboratory operated under the direct and personal supervision of a physician so qualified should be eligible to furnish them. However, in the interest of quality of service and the public health, services required by the Sanitary Codes of the State or New York City to be performed by laboratories approved by their Health Departments, should be furnished only through such laboratories.

Visiting Nurse and Home Nursing Service

For economy and simplicity of administration, to permit the proper use of registered practical nurses, and to integrate the nursing benefits under an insurance program with the services now provided by public and private agencies, visiting nurse and home nursing benefits should be provided only through established nursing agencies. The insuring agency should purchase such service at cost on a per-visit or hourly basis pursuant to contracts with non-profit visiting nurse associations, and contracts with political subdivisions of the State providing public health nursing service by or under the responsible supervision of nurses qualified by the Sanitary Code of the State, or by regulation of the City of New York. The insuring agency, and the Commissioners of Health of the State of New York and the City of New York for their respective jurisdictions, should jointly approve the organization and standards of the nursing services with the objective of coordination, and the maintenance and promotion of good standards of nursing care.

Hospital Service

In some proposed insurance plans, only non-profit and public hospitals would be permitted to participate, but the experience of the Blue Cross plans and the Emergency Maternity and Infant Care Program in New York State has been such that there seems to be no reason why proprietary

hospitals should not participate; in fact, they would be necessary to provide facilities in a number of rural areas. It would be desirable, however, to have a hospital licensure law to assure the quality of service rendered by all hospitals.^{9/} Because there are several communities on the borders of the State whose residents customarily avail themselves of hospital facilities in neighboring communities beyond the State line, such hospitals should be permitted to apply for participation on the same basis as hospitals located within the State. Provision should be made for emergency care in unapproved (i.e., non-participating) hospitals within or outside of the State, to be paid for at a lesser, uniform rate.

Participating hospitals should agree to furnish complete service as far as possible, and to accept no additional payment from beneficiaries except for more costly accommodations than those covered by the basic rate of payment. In recognition of the difficulty that small rural hospitals might have in providing certain services, such hospitals should not be excluded from participation because medical social service, physiotherapy, diagnostic x-ray and radiotherapy, anesthesia, clinical laboratory service and other hospital services were not furnished if, in the opinion of the insuring agency, such services could not reasonably be made available. It would seem, however, that adequate rates of payment to such hospitals, on a cost basis, would assist and encourage the development of additional services.

Other Services and Participants

Any optometrist registered under the laws of the State should be eligible to participate as an individual. In view of the established practice, and the legal requirement that physiotherapists^{10/} and dental hygienists^{11/} practice only under the supervision of licensed physicians or dentists respectively, it would seem desirable that the extent and type of their participation should depend on, and that services rendered by them should be in the name of, the supervising physician or dentist.

Authorization of Service

General medical and dental service. Under most public medical care programs it is required that service be authorized in advance by the wel-

^{9/} See Chapter XIV for rough outline of such a law, and Chapter XVII for an expression of the favorable attitude of the State Hospital Association toward a single, uniform system of inspection and approval of hospitals.

^{10/} State Education Law, Section 1262.

^{11/} State Education Law, Section 1306.

fare agency. However, under voluntary insurance programs, general medical service is accessible to the patient without authorization by the insuring agency, and this method would seem to be desirable for compulsory plans as well.

Specialist service. A distinction may be made between consultation and treatment. Consultation service is generally considered rather as an aid to the attending physician than to the patient directly, and as a service which should be provided only upon written referral or order of the attending physician. This procedure should not involve authorization by the insurance agency, but copies of the recommendations should be filed to afford a mechanism whereby abuses might be detected.

An order or referral should not be required in the case of certain treatments or services by specialists (e.g., eye refraction, health supervision of apparently well children by qualified pediatricians, etc.). The exact nature of these exceptions should be decided by the insurance agency, acting with professional advice.

Hospital service. The medical needs of the patient should be the determining factor in admissions to hospitals, and except in an emergency no patient should be admitted without having been referred by a physician. If a question should arise as to the need for hospitalization, the hospital director should have the right and duty to consult with the referring physician to determine the necessity for hospitalization; in case of disagreement, the patient should be admitted and the matter referred immediately to the insuring agency for decision.

There should be no limit on the duration of hospitalization for patients whose medical needs require hospital care. However, in the interest of conserving and efficiently utilizing existing hospital facilities, a period of about fifteen days in any one illness should be the maximum allowable, unless application for an additional period was made by the hospital director and approved by the insuring agency. The length of the additional period approved should depend on the medical needs of the patient. In the case of admission for tonsillectomy and other minor operations, a shorter allowable period prior to application for renewal should be fixed. The maximum allowable periods of hospitalization without approval should be subject to further regulation by the insuring agency in the light of actuarial experience.

The time when the patient should be discharged from the hospital would ordinarily be determined by the attending physician, but if the insurance agency had reason to believe the stay to be excessive, it should

have the right to require the attending physician and hospital director to justify the extended stay.

In epidemic periods or under other special circumstances when hospital facilities might not be available, the insuring agency should provide nursing service pursuant to contract with an approved nursing agency, in the patient's home or other suitable place, in lieu of hospital service.

Other services. X-ray, laboratory, visiting nurse, and similar services should also be provided on the order of the attending physician. It is common practice, however, for certain services which are susceptible of excessive use to be provided initially on the recommendation of the attending physician, but to be continued beyond a certain point only upon authorization of the insuring agency. Such services might be x-ray diagnostic and radiotherapy service, laboratory service, physiotherapy and visiting nurse service. Also, in the case of special service for which a referral or order by a physician was not required, e.g., optometric service, approval by the insuring agency might be required for service in excess of a prescribed maximum.

Inclusive services. Services provided on an inclusive basis, e.g., specialist and laboratory service by groups caring for patients on a capitation basis, or x-ray and laboratory examinations included in hospital service, would not need to be subject to written order, or approval by the insuring agency.

Acceptance of Patients

An individual practitioner rendering service under an insurance program should have the same right to accept or refuse a patient without interference by the insurance agency, as the patient has the right to select a practitioner, group or hospital without interference. In the category of institutions, however, which would include medical and dental groups as well as hospitals, a responsibility to the public as a whole has been imposed by their incorporation under the laws of the State. Participating hospitals and groups should at the time of approval specify the types of cases for which they would be equipped to care, and subsequently should be obliged to accept all patients conforming to such types, without any discrimination.

Payment of Physicians and Dentists

Earlier in this chapter the relative advantages and disadvantages of salary, capitation and fee-for-service payments were discussed briefly,

with the conclusion that the fee-for-service method was the one best suited to the needs and wishes of the people, and the one which would be chiefly used, although not necessarily to the exclusion of the other methods.

Salary. It has been suggested that in certain circumstances, such as in rural areas where the population which could be conveniently covered by a physician would not be sufficient to adequately compensate him on the basis of fees (or capitation), an adequate salary might be offered as an inducement to practice in such area. Difficulties would probably be encountered in the adoption of such a method by an insurance plan, however. Such areas are usually not definitely circumscribed, and it would be troublesome to determine what patients should be assigned to the salaried physician, whether they might turn to other physicians for certain services, what services the salaried physician would be expected to provide, etc. It would seem best to provide subsidies in addition to fees, rather than salaries, to induce physicians to locate in sparsely populated areas. In respect to children's dentistry, the insuring agency should have authority to provide dental care in remote areas through salaried dentists, working perhaps in an itinerant dental clinic such as described in Chapter V. Compensation on a salary or per-session basis might also be employed to pay specialists to visit rural areas periodically for consultations with local physicians.

Capitation. This method of payment exerts an appeal because it would eliminate many accounting procedures necessary under the fee-for-service method and because, if it applied to all of the population or to certain geographic units, it would make possible an exact prediction of expenses.

The related problems of excessive demands of patients for service, and a tendency of physicians to provide less than the necessary volume of service which might arise from the capitation method would be a matter for adjustment between physician and patient, and the insurance agency would be largely relieved of the necessity of attempting to control an excessive use of service which might occur under fee-for-service practice. On the other hand, capitation would seem to be a feasible method only under a program, such as that in Great Britain, which was limited to general practitioner service,^{12/} or where a very definite distinction could otherwise be made between general medical service and special medical service. Such a distinction does not seem possible as medicine is practiced today. For example, many cases of heart disease can be treated

^{12/} For descriptions of the capitation method in Great Britain and New Zealand, see Chapter XV.

very satisfactorily by a general practitioner, but others require the services of a specialist, either for diagnosis or for continued supervision and treatment. If general practitioner service was available on a capitation basis, and specialist service on a fee-for-service basis (both without cost to the beneficiary), the general practitioner and patient would both be inclined - the one to relieve himself of work, the other to obtain care which he fancied was superior - to turn to the specialist for care which could be given very well by the general practitioner. A partial remedy for this situation would be to place specialists on a salaried basis. A complete solution would require some penalty for the general practitioner who referred an excessive number of patients in an attempt to escape his obligations. Because any such penalty would logically be based on the volume of service provided by the general practitioner, the whole system might ultimately assume the characteristics of a fee-for-service system.

The inclusion of the capitation method in a comprehensive benefit system would seem to be workable only if all types of medical service were to be provided on such a basis. For this reason, it was suggested that capitation be limited to approved medical (and dental) groups which would be required to furnish all necessary service. If any services were outside of the capability of the group, they would have to be paid for by the group rather than the insuring agency. In addition, the method suggested in Chapter XXIII, of permitting beneficiaries to obtain services through union, industrial, non-profit and other private (commercial) insurance plans, could be adapted to provide, in effect, an extension of the general features of the group and other capitation methods.

Fee-for-service. Under this method, payment may be on a service basis, i.e., for a specified service the physician or dentist agrees to accept the stipulated payment by the insurance agency as full payment, or on an indemnity basis, i.e., for a specified service the physician or dentist may exercise the right to charge the patient in addition to the fee received from the insurance agency.

Many voluntary plans employ a combination of the service and indemnity methods, the former being reserved for payments in the case of patients or families below a certain income level. This method would seem feasible under a compulsory insurance program, and would be relatively simple if the financial status as determined by the amount of tax paid in the previous year were used to determine eligibility. It would, however, probably involve some notation on the beneficiary's registration card,

which, it is believed, would be objectionable. If not, or, if there were in addition the necessity of appealing to a review board for relief from excessive charges, there would be introduced an element of bureaucracy which it would be desirable to avoid.

A more suitable method would seem to be one which permitted the patient to negotiate directly with the physician or dentist rendering care to determine whether any charge in excess of the fee schedule was to be made, and to provide no mechanism for arbitration by the insuring agency. (In the New Zealand plan, which employs this method, the patient's case is strengthened by the fact that except in certain unusual circumstances the physician has no legal means of collecting charges in excess of the scheduled fee.) In addition, use might be made of a principle employed by some voluntary plans wherein fees for "participating" physicians are scheduled at a higher rate than those for "non-participating" physicians, but the payments due the former may be subject to pro-rating if the expenses exceed the income of the plan. It would seem that under a compulsory program covering all of the population, in which circumstances a distinction between participating and non-participating physicians could not or should not be imposed, a positive inducement to render care on a service basis might be afforded by guaranteeing payment at the full scheduled rate to physicians, dentists and approved groups who would agree to provide care without making any additional charge to the patient for services covered by the program. Payments to physicians, dentists and groups who reserved the right to make extra charges to the patient would be pro-rated from funds remaining after commitments to the persons and agencies providing care on a service basis had been met. In this fashion there would be no distinction between beneficiaries according to economic status.

It is generally understood that a majority of the State and national proposals for compulsory medical insurance would provide care entirely on a service basis. Although it is true that they do not specifically sanction the indemnity method, it is also true that they do not specifically prohibit such method. Recognizing that physicians and dentists vary according to skill, popularity and other factors not susceptible of accurate definition, it would be expected that payments in excess of the fee schedule would be demanded, or received indirectly in the form of gratuities, etc., by practitioners whose services were prized more highly than the average. The only recourse that the patient would have against

overt demands would be in the form of an appeal to the insuring agency. The New Zealand plan has boldly regularized the practice of extra charges, which would probably occur in any event. The combined service and indemnity method suggested in the preceding paragraph would sanction the practice of permitting charges in excess of the fee schedule but would attempt to provide safeguards through financial inducements incorporated in the plan itself, and to avoid, as far as possible, tedious appeals and red-tape.

Payment for Other Services

X-ray, physiotherapy and laboratory service. One of the purposes of employing the indemnity system of paying physicians and dentists for most of their services is that it permits great latitude in the selection of a practitioner, and leaves for decision by the patient and practitioner the value of services, which in many instances are not uniform, and into which there enters a considerable degree of personal relationship. However, there are certain services, such as physiotherapy, optometry, x-ray and laboratory service, which seem to be essentially uniform in content from place to place and practitioner to practitioner. It would seem that for these services, which except for optometry are provided more as an aid to the attending physician than as a direct personal service to the patient, payment on a service basis would be justified.

Visiting nurse service. This service seems to be essentially uniform in content from agency to agency. It would be provided by non-profit or public agencies on a cost basis, and there would therefore seem to be no good reason for permitting extra charges to patients.

Hospital service. Varying practices are observed or proposed with regard to payment for hospital service. A number of plans pay a fixed amount per diem to apply against hospital charges. Others pay a negotiated rate which is uniform for all hospitals within a given area. Another practice is to pay the hospital charges, which are not necessarily the same as the costs. What seems to be a superior method is the one of paying costs, somewhat as developed under the Emergency Maternity and Infant Care Program.^{12/} This method has the virtue of encouraging hospitals to provide services in addition to bed and board and nursing care, and of recognizing variations in cost according to type of hospital. However,

^{12/} See Chapter V and Chapter XIV. .

in order that inefficient or unduly expensive practices would not be encouraged, it would be necessary to place a ceiling on the rates of payment. Although a uniform ceiling would be the simplest, the most equitable would seem to be one related to average or median per diem costs for comparable hospitals. In determining comparability, there should be taken into consideration geographic location, size, type of service and other factors which would have a bearing upon the costs of operation.

Methods of Billing for Payment

Under the New Zealand system, three methods of billing are provided for practitioner services: (1) the physician may bill the government directly when accepting the government rate in full payment for the services rendered; (2) the physician may bill the government directly, and separately charge the patient a fee in excess of the government rate; and (3) the physician may bill the patient directly, charging either the government rate or a larger fee, the patient paying the physician directly and using his receipt to obtain a cash refund from the government.

In many voluntary plans the physician first bills the insuring agency, charging either the rate established in the fee schedule or a higher fee. The insuring agency then remits payment to the physician for allowable charges and, after noting on the bill that payment has been made on his behalf, forwards the bill to the patient - for the patient's information only in case no extra charges are due, or for the patient's action in case extra charges have been made by the physician. This method is simple and has the advantage of emphasizing to the patient the fact that the insuring agency has made payments on his behalf. The same general method might be employed to pay dentists, hospitals, etc. In any event it should be permissible for the patient to pay at the time the service was rendered any excess charges which he might have incurred for more costly hospital accommodations, etc., such payment being noted on the statement made to the insuring agency by the physician, dentist, hospital, etc. In no event should cash payments or refunds be made to the patient.

CHAPTER XXII

REVENUES FOR MEDICAL CARE

General Characteristics

Revenues for a medical care program, unlike taxes for other forms of social insurance, such as Unemployment Compensation and Old Age and Survivors' Insurance, do not tend to be deflationary since the accumulation of a large reserve is not required. The demands for medical care by a large population unit are steady and predictable, and a very modest reserve will suffice; in fact, the absence of a reserve fund may deliberately be employed as a deterrent to the excessive use of certain benefits which are not readily controlled by administrative methods and which are not much influenced by epidemic or other unpredictable factors.

The methods employed in obtaining revenues for a compulsory medical care program should be related to the general objectives of the program and the classes of the population that it is designed to cover. Insurance premiums are ordinarily graded according to the individual risk; e.g., age at enrollment and health status are important factors in determining the premium rate of privately underwritten life insurance. On the other hand, the premium rate is not graded in accordance with ability to pay. In the field of medical and hospitalization insurance, the age, sex, marital and family, occupational, and health status of the persons covered are very important in influencing the claims that may be made for benefits by persons in various categories. For example, the annual actuarial value of a reasonable comprehensive policy may be \$20 for a single person, \$40 for a family consisting of husband and wife beyond child-bearing age, \$55 for a family consisting of husband and wife of child-bearing age, and \$95 for a family consisting of husband, wife of child-bearing age and two children. In voluntarily purchased medical and hospitalization insurance, notably that written by non-profit organizations, there is an increasing tendency to disregard such actuarial differences in fixing premiums. Family contracts covering husband and wife with or without children, and without regard to age, may call for the same premium. Single person contracts often call for relatively higher premiums than family contracts. However, the extent to which this practice may be carried is limited by the fact that if all differences are ignored as between single persons and family groups, etc., persons to whom the policies have actuarial values markedly less than the premiums will not enroll, and a compensating rise in the premium must result if the insurance corporation is to remain

solvent.

Compulsory medical insurance makes little or no distinction among the various select groups described,^{1/} the rationale being that eventually all covered persons will enter the system at birth, and as they progress through life they will at some periods pay more than the actuarial value, and at some periods less, but in the course of a lifetime they will be subject to essentially the same variations as everyone else. Compulsory medical insurance also goes beyond voluntary insurance in grading premiums roughly according to ability to pay. Again the rationale is somewhat similar; the child pays nothing but the adult pays relatively large amounts in the periods when his earning capacity is high and relatively small amounts when his earning capacity is low.

It is desirable that the methods of obtaining revenues for compulsory medical care programs be equitable among persons of differing economic status, that they shall not have an adverse effect on business conditions, and that they may be collected as simply as possible. The tax contributions should preferably be levied separately from general taxes, and each self-supporting adult should make at least a small individual contribution so that he will regard the program as a contributory one requiring his cooperation for its efficiency, rather than as a public service supported wholly from tax funds and in the success of which he has no direct and personal interest. A plan to be administered without proof of financial need, and as an individual security rather than a public protective measure, should derive its revenues entirely from the persons who stand to benefit by it. In the interest of prudent expenditures and sufficient revenues, the agency administering benefits should be the agency responsible for or very closely associated with the determination of the nature and rate of contributions.

A wide choice is possible among methods of financing, but one characteristic common to practically all compulsory plans is that contributions or taxes are graded in accordance with ability to pay, usually as a percentage of wages or total income.^{3/} Table 1 shows the methods of financing employed in the major national compulsory health insurance plans. The methods of obtaining revenues for medical care programs may be classified into three groups:

1. A tax on wages and salaries primarily. It may be borne by employee

^{1/} In some instances a nominal extra charge or a registration fee may be imposed for adult dependents.

^{3/} Only Ireland and Great Britain impose a uniform premium, which method is soon to be abandoned by the latter.

Table 1. Financing of Existing National Compulsory Health Insurance Plans.^{2/}

COUNTRY	CONTRIBUTORS			CONTRIBUTIONS				Insured Divided into Wage Classes
	Insured	Employer	State	Type		Amount		
				Flat Rate	Percentage of Wages	Total	Insured	
AUSTRIA..	50%	50%	No					No
BULGARIA..	33-1 3%	33-1 3%	33-1 3%		X			Yes
CHILE.....	24%	59%	17%		X	8-1/2% of weekly wage	2% of weekly wage ¹	
CZECHOSLOVAKIA.....	50%	50%	No		X			Yes
DENMARK.....	X	No	S ²				Average weekly contribution is 0.41 krone	
FINLAND.....	39%	39%	22%	X			4d weekly	No
ESTHONIA.....	50%	50%	No		X		1% to 2% of wages	Varies
FRANCE.....	50%	50%	S		X	8% of wages	4% of wages	
GERMANY.....	50%	50%	No		X	Cannot exceed 6% of wages		
GREAT BRITAIN.....	43%	43%	14%	X			5-1/2d ³	No
GREECE.....	X	X	No				1.6% of mid-point of wage class	Yes
HUNGARY.....	50%	50%	S			Cannot exceed 6% of wages		Yes
ITALY.....	50%	50%			X	3% of daily wage ⁵		
JAPAN.....	45%	45%	10%		X		Cannot exceed 3% of wages	No
LATVIA.....	37-1/2%	37-1/2%	25%		X		Cannot exceed 2% of wages	
LITHUANIA.....	33-1 3%	33-1 3%	33-1 3%		X		Cannot exceed 3% of mid-point of wage class.	Yes
LUXEMBURG.....	66-2/3%	33-1 3%	S		X	Cannot exceed 4.5% of normal wage		
NETHERLANDS.....	50%	50%	No		X			
NEW ZEALAND.....	X		X		X		£1 a year plus 5% of income	No
NORWAY.....	60%	10%	20%		X			
PFRU.....	X	X	S ²		X			
POLAND.....	40%	60%			X	6.5% of basic wage		Yes
PORTUGAL.....	X	X						
RUMANIA.....	X	X	S		X	Cannot exceed 6% of midpoint of of wage class		Yes
SWITZERLAND.....	X		S ²					
U.S.S.R.....	No		100%					No
YUGOSLAVIA.....	50%	50%	No		X			Yes

¹ Covers all branches of social security.² S — Subsidy.³ Communes pay a large share of the costs.⁴ Plus cost of central administration.⁵ Figures are for men.⁶ For land and river transport workers.⁷ Commune pays 10% of cost.⁸ Equal to half the contributions.⁹ Also cantonal subsidies, communal subsidies and employers' subsidies.

^{2/} Health Insurance, Special Committee on Social Security, House of Commons, Ottawa, 1943. Credited to Approaches to Social Security: An International Survey, International Labour Office, Montreal, 1942.

- and/or employer, and is sometimes supplemented by general taxes. This type usually covers 50 per cent or less of the population.
2. General taxes alone. This type of plan may cover all or only a portion of the population.
 3. A tax on all personal income of individuals. It is sometimes supplemented by general taxes. This type usually covers the entire population.

Financing Through Individual Contributions, by Taxes on Wages

The method most frequently employed in national compulsory health insurance plans, and the one which has most often been proposed for State and Federal plans in this country, is the one which places a tax on wages, as illustrated in Table 2.

Table 2. Health Insurance Financed Through Individual Contributions, by Taxes on Wages

Source of revenue	Remarks
Employee only	Proposed for Rhode Island compulsory hospital insurance
Employee & employer	Austria, Czechoslovakia, Germany, Greece, Netherlands, Yugoslavia
Employer only	Workmen's Compensation
Employee & general taxes	Not proposed or in effect
Employee & employer & general taxes	Proposed in numerous state plans and Wagner-Murray-Dingell Bill; in effect in Bulgaria, Chile, Eire, Great Britain, etc.
Employer & general taxes	Proposed for New York State, 1945, by S.479, A.251, A.141

The advantages of a tax on wages are: the ease of collection through payroll deduction; the adherence to a method of contribution accepted for other forms of social security, such as Unemployment Compensation and Old Age and Survivors Insurance; the collection of the tax at the source of income will make it relatively less "painful" because it is collected as earned and does not have to be paid out from savings; by the inclusion of dependents of wage-earners, a proportion of the population as large as 50 to 60 per cent, a majority of whom will have low incomes, may enjoy benefits; and the possibility of dividing the tax between employer and employee. Practically all plans require joint contribution by worker and employer,^{4/} it being easier to persuade the two parties to share the

^{4/} There seems to be no logic in imposing a tax of this nature on the employer. The custom may have arisen from the early theory of responsibility of the master for the welfare of the servant. Practically, it seems to be a device whereby the employee seems to get something for which he does not have to pay, although ultimately a tax on employers may prove to bear relatively more heavily on the low-income wage or salary earner than a tax which does not apply to employers.

tax than to impose it wholly on one or the other; in addition, many plans receive a substantial proportion of their income from general tax funds. The contributory element of a tax on wages helps to assure that the statutory benefits will be paid regardless of current economic conditions, whereas in plans financed wholly by general tax funds there is the danger that benefits will be reduced if general revenues decline due to unfavorable economic conditions. The contributory feature also makes it possible for contributors to regard benefits as a right rather than as a charity.

The disadvantages of a tax on wages are: the number of persons covered and the income of the system will be lowest when employment is lowest, although this may be the time of greatest need; persons paying taxes on wages below a certain level may not be eligible for benefits; and the difficulty, if not impossibility, of covering a proportion of the population, as large as 40 to 50 per cent, which is made up to a considerable extent of families where the wage earner is self-employed or engaged in agriculture, domestic service, etc., and where the need for insurance is as great or greater than that of the industrial worker. A number of plans of this type have proposed to offer insurance on a voluntary basis to those ineligible to participate through payment of a tax on wages but, unfortunately, many of these people are financially unable to pay the voluntary premium. In some plans the individual would pay the entire cost of the voluntary premium; in others it is proposed that the State and individual would share the cost. Another obstacle to covering these persons on a voluntary basis is that because group enrollment is not usually feasible under these circumstances, a physical examination might be required,^{5/} which would result in the exclusion of persons able to pay the premium. One plan, however, proposed to permit self-employed wage-earners (although the definition of this group would seem difficult) to pay taxes and receive benefits on the same basis as employed wage-earners.

A tax on wages tends to be inequitable if the entire population is not covered, and especially if the employer is also taxed, because the amount of the tax is largely added to the cost of the product or service, as is a general sales tax. A tax of this type bears relatively more heavily on the lower income groups, and forces persons who are not insured

^{5/} A physical examination was required for voluntary coverage in several bills that were proposed in New York (Assembly Int. 1452, 1944; Assembly Int. 260, 1945).

to contribute indirectly to a system from which they receive no benefits. If general taxes are used to supplement contributions by employer and employee, or by employer alone, the revenue plan is even less equitable. Contributing to the generally inequitable nature of a tax on employers is the fact that whereas in certain circumstances, such as those covered by the Workmen's Compensation Law, the employer has and is required to meet a definite responsibility arising from conditions of work and logically chargeable to the cost of the product, the same responsibility does not hold in the case of non-work-connected medical conditions of employees and their dependents.

A further disadvantage of a tax on wages on a State basis is the handicap to the employer who must market his goods in competition with out-of-State employers who do not have to contribute some portion of their payrolls to an insurance plan. In connection with the latter, the New York State Commission to Formulate a Long Range Health Program, which made a study of this subject, concluded that:

If an individual state with a substantial industrial population adopts either a compulsory health insurance scheme, or a tax-supported program on a larger scale than before, industry residing in such a state may be put in a less favorable competitive position than industries in other states with less financial obligation. This might lead to the moving of industry from a state with a definite medical care program to a state without any program. 6/

As a practical consideration, a tax on wages constitutes a formidable obstacle to the ultimate objective of including the entire population, because once the pattern is fixed it would be most difficult to change to an alternative method of financing which would almost certainly be necessary if all other persons were to be covered. Employees benefiting by a contribution made by the employer would not be expected to accede readily to a change requiring them to bear the entire tax in common with the group outside of covered employment. Also, the rate of utilization of medical care is less for regularly employed persons than for the remainder of the population, and these employed persons, able to lend force to their wishes through labor organizations, might successfully oppose the change to a system which would result in a higher total tax rate owing to the inclusion of persons with a higher rate of utilization of medical service.

The coverage and the tax base that would be furnished in New York State by persons covered by the State Unemployment Insurance Law, ^{7/} is 7/ Covers employees in establishments of 4 or more, exclusive of governmental employees, railroad and agricultural workers, domestics, and employees of charitable, religious, scientific and educational institutions.

Table 3. Estimated Number of Employees and Dependents Covered, and Income Available for Taxation, Under Coverage Afforded by Unemployment Insurance Law, New York State

Year	Millions of workers covered ^{a/}	Millions of persons covered ^{b/}			Millions of persons covered ^{c/}			Taxable income ^{d/} (millions)	Total income ^{e/} (millions)
		Employ-ees	Employees and dependents		Employ-ees	Employees and dependents			
			Number	Per cent of population		Number	Per cent of population		
1938	4.16	3.09	5.18	44.9	2.91	5.53	40.2	\$4,514	
1939	4.45	3.20	6.40	46.5	3.12	5.93	43.1	4,725	
1940	4.80	3.33	6.66	48.4	3.35	6.38	45.4	4,802	
1941	5.30	3.57	7.34	54.4	3.71	7.05	51.3	5,533	\$5,337
1942	5.80	3.82	7.64	56.6	4.06	7.71	56.1	5,589	5,404
1943	6.00	3.99	7.93	59.1	4.20	7.55	55.0	7,772	7,554
1944	6.00	3.96	7.90	58.5	4.20	7.56	55.0	8,125	9,617
									9,583

a/ Number of workers covered for any period or wage, however small. Industrial Bulletin, New York State Department of Labor, March - April 1945.

b/ Coverage estimated on basis of average monthly employment, op. cit., and assumption that there is an average of one dependent per employee.

c/ Coverage estimated on basis of employees with earnings of \$500 or more annually in covered employment (figure taken as 70 per cent of total on basis of actual figures of 58.9 in 1938 and 58.4 in 1942), and, as in California, an average of 0.9 dependents per employee in period 1938-41, and 0.8 in period 1942-44.

d/ First \$3,000 of earnings.

e/ Figures furnished by Division of Placement and Unemployment Insurance, New York State Department of Labor.

indicated in Table 3. This selection was made for illustrative purposes because it comprises the group which has been most often proposed for coverage by compulsory health insurance. In estimating the number of persons who would be covered, i.e., who would be eligible for benefits, a minimum wage must be taken into consideration. As an extreme example of the situation that might apply if there were no minimum, a person might engage in covered employment for only one day, pay a tax of \$0.15 and become eligible for several hundred dollars worth of benefits. Some plans or proposals have gone so far as to require a full year in covered employment as a condition for eligibility, but a majority base eligibility on two factors - length of time and earnings in covered employment - the latter ranging from \$200 to \$500. Because the value of a year's eligibility for benefits would be from \$65 to \$125 for an employee and dependents under a reasonably comprehensive program, it would seem that he should earn in covered employment a sufficient amount to have paid in, at a tax rate of 3 to 4 per cent, at least one-third of the annual average value of benefits; i.e., the payment of tax on minimum earnings of \$500 or \$600 should be required.

Exact figures are not available as to the additional number of persons that would be covered if governmental employees, railroad workers, and employees of charitable, religious, scientific and educational institutions were included. The first group numbers about 450,000, exclusive of employees of Federal war agencies,^{8/} and the second about 250,000. Altogether, a total of perhaps 750,000, of whom 90 per cent might be eligible and who, with their dependents, would number about 1.2 million, an additional 9 per cent of the State's population, would be eligible for benefits. The number of wage and salary earners with earnings in excess of \$500 probably could not greatly exceed a total of 4.95 million because in 1940 the total number of persons in the labor force, employed and unemployed, amounted to only 5.67 million;^{9/} in fact, many of the persons covered under a wage-tax revenue plan would be non-residents employed in New York State - perhaps a million or more - and the percentages of the State's population covered would not be as great as the figures cited would indicate.^{10/} On the basis of earnings under Unemployment In-

^{8/} Industrial Bulletin, New York State Department of Labor, January-February 1945.

^{9/} 16th Census of the U.S., 1940, Population, Third Series, the Labor Force.

^{10/} An anticipated difficulty in administering this type of plan would arise in connection with registration of dependents of non-residents for eligibility for benefits, a difficulty not encountered under Unemployment Insurance, because the person taxed or insured is the sole beneficiary.

insurance, it is estimated that the inclusion of governmental employees, railroad workers, etc., would add \$1,000 million to the taxable income under \$3,000, and \$1,200 million to the taxable income from all wages and salaries.

Financing Through General Taxes

Medical insurance programs in most countries have begun by covering industrial wage earners only. In only a few, and these where independent workers such as farmers form an important group, has an attempt been made to cover the entire population. However, the trend seems to be strongly toward coverage of all members of the population. With universal coverage as an aim, the method of financing through general taxes makes an appeal because of its simplicity and adherence to accepted practices. At present, only the Soviet Union finances medical care for the general population from general taxes.^{11/} In this country, the people of Arkansas in 1944 voted on a bill which would provide hospitalization for the indigent at State expense, low-cost hospital care for others through the use of general tax funds, and low-cost diagnostic service to all (also from general tax funds) without regard to ability to pay.^{12/} The Arkansas program was to be financed by a tax on all natural resources "severed from the soil or waters of the State" - lumber, oil, coal, ores and minerals, and by a tax on electric current, except that manufactured by municipalities for their residents.

As against the advantages of affording the opportunity for immediate complete coverage of the population, and its relatively "painless" nature due to indirect collection, the disadvantage of a general taxation plan seems to be that the beneficiary of the medical program may tend to hold the benefits cheaply, as being a largess of government rather than a service for which payment is made individually and with some relation to benefits to be expected, and which should be used with regard to the wise expenditure of fund. Further, being subject to budgetary control and not depending on a self-supporting fund, the danger exists that in times of economic stress the benefits may be considerably reduced.

The sources and amounts of revenues of New York State for 1944-45 are shown in Table 4. Although the present State tax structure might support a modest medical care program from general funds, it would seem

^{11/} Not properly termed medical insurance, since it is more nearly a state public service than a risk-sharing enterprise.

^{12/} The bill (Hollingsworth State Hospital System Act, 1944) was defeated by a vote of 44,333 for and 142,554 against.

Table 4. New York State Revenues, Year Ended March 31, 1945^{13/}

Item	Amount a/ (thousands)
1. Personal income tax	\$111,032
2. Total general business taxes	172,749
a. Corporation tax, article 9	31,099
b. Utilities tax, article 9	398
c. Corporation franchise tax, article 9-a	104,268
d. Unincorporated business tax	27,300
e. Bank tax	7,639
f. Insurance premium tax	2,045
3. Total excises on consumption	132,956
a. Motor vehicle tax	33,248
b. Motor fuel tax	40,408
c. Alcoholic beverage tax	25,925
d. Alcoholic beverage control licenses	9,919
e. Cigarette tax	23,456
4. Total taxes on transfers and exchanges	76,119
a. Inheritance and State taxes	27,908
b. Stock transfer tax	20,364
c. Pari-mutuel tax	27,847
5. Miscellaneous taxes	2,812
6. Miscellaneous revenues	21,379
7. Total taxes and revenues	517,047

a/ In addition the State acted as a collection agency for the localities of the State to the extent of \$100,352,352 collected on items 1, 2-b, 2-c, 3-a, 3-b, 3-c and 3-d, and distributed directly to the localities.

that fairly comprehensive programs involving annual expenditures of from \$250 to \$450 million would require a marked increase in personal income tax rates, or the addition of a sales tax, or both. The latter alone would not suffice unless the rate were very high or unless basic commodities were taxed. A 2 per cent sales tax in New York City realized only \$53.8 million in the fiscal year 1939-40, and a 1 per cent tax brought in \$32.9 million in 1942-43.

Financing Through Individual Contributions, by Tax on Personal Income

The method of financing medical care or insurance programs chiefly through a tax on personal incomes is a relatively new one. The advantages are: the entire population may be covered and the troublesome distinction between insured persons, the indigent and other non-insured persons is avoided; all or a very large portion of the tax may be graded in accordance with ability to pay; the industry of one State will not be placed at a competitive disadvantage with that of another; and the insurance principle may be incorporated to the extent that the beneficiary pays individually and directly for at least some part of the service to be received. The

chief disadvantage would seem to lie in the formidable administrative problem of obtaining contributions from all persons with income.

Financing through a tax on personal incomes only, or personal income plus general taxes, is not in effect nor has it been proposed for State or Federal programs in this country. The compulsory medical insurance plan enacted by the Province of Ontario in 1945^{14/} in anticipation of a general Dominion plan requires that a substantial portion of the cost of insurance be raised by general municipal taxes or a fixed payment (individual premium) by persons over 16 years, or by a combination of the two, plus a contribution from the Province which is to be derived in part from a special Dominion personal income tax for medical insurance.

New Zealand plan^{15/} In New Zealand a combination of a personal income tax, a company net income tax, general taxes, and a per capita or personal registration tax for persons 16 years and over has been successfully employed since 1938 for financing medical insurance and other social security benefits.^{16/}

A tax is imposed on wages or salary at the rate of 5 per cent of gross income from these sources, with no exemptions or deductions for dependents. The tax is deducted at the source by the employer, who affixes social security stamps to the wage record. Wages and salaries include all compensation received by employees, wages paid part-time or casual workers, pensions and annuities from employers, bonuses and gratuities, commissions and fees, food and lodging allowances, and food and lodging in lieu of cash wages.

A tax of 5 per cent must be paid quarterly on all other income, except by totally disabled war pensioners. Companies pay 5 per cent of net income. Individuals may deduct necessary business expenditures, depreciation charges, business losses and the like, from income other than wages or salaries, but there is no personal exemption nor are deductions allowed for dependents. Income exempt from taxation includes: benefits under the Social Security Act, war-service pensions, workmen's compensation, sick benefits from a voluntary society, dividends from a company liable to the tax on company net income, income from other Dominions sub-

^{14/} Ontario Municipal Health Services Act, 1945. The act, which is in the form of an enabling act for municipalities, had not been placed in operation up to December 1945.

^{15/} Cash Benefits under the New Zealand Social Security Program, Bureau Report No. 13, Bureau of Research and Statistics, Social Security Board, Washington, 1945. See also Chapter XV.

^{16/} The tax rates quoted cover not only medical benefits, but all types of social security benefits - old age, invalids', widows', orphans', family, sickness, unemployment, emergency and certain other benefits.

ject to similar taxes, scholarships, contributions by employers to an approved employee benefit fund, income received by officials of foreign countries, and pay received by members of the armed forces.

All persons reaching age 16 are required to register and to pay annually a fee of 5s. for women and for men aged 16 to 20, and 5s. a quarter for men 20 and over. A registration fee coupon book is obtained at the

Table 5. Sources of Income of New Zealand Social Security Fund, 1942-43

Source	Per cent of total
Wage and salary	47.1
Other personal income	16.7
Company income	8.8
Registration fee	3.4
General fund	23.7
Miscellaneous	.4
Total	100.

post-office, where the appropriate coupon is detached, the receipted stub being proof of payment. Employers are required to inspect registration books quarterly and deduct any unpaid fee. Persons exempt from the registration fee are: totally disabled war pensioners, per-

sons having as income only certain social security benefits, persons in certain institutions and without income, registered unemployed persons, students without income, members of religious orders and official representatives of other governments. The distribution of revenues by source, which is relatively constant from year to year, is shown in Table 5.

Miscellaneous Methods

Various combinations of taxes on wages or salaries, personal income and employers, and general taxes are possible. A method of current interest is that proposed in Canada.^{17/} The plan would cover everyone by providing free medical service for children up to age 17, by requiring adult income recipients who are able to do so to pay the full cost of service for themselves and their adult dependents, and by turning to the employer for subsidy of wage earners and their dependents and to Provincial general funds for subsidy of other persons unable to pay the full cost. The cost of care for children would be distributed equally between insured person and general Dominion funds derived from a special personal income tax. Table 6 has been adapted from the statement of estimated contributions^{17/} to show the percentage distribution for each class of beneficiary. From the standpoint of collection, insured persons are divided into two groups: employed insured persons and assessed insured persons. The payments of individuals within these classes has been so devised that

^{17/} Health Insurance, Report of Special Committee on Social Security, House of Commons, Ottawa, 1943.

Table 6. Approximate Distribution of Payments for Health Insurance, by Sources of Payment and Earnings Classification, Proposed Canadian National Health Plan.

Classification	Per cent distribution of payments			
	Empl- oyee	Empl- oyer	Assess- ed con- tribut- ors	Govern- ment
Income recipients				
Employees, full-time	75	25	0	0
" , broken-time	50	16	0	34
" , paid, in kind	0	100	0	0
Working proprietors	0	0	70	30
Other income recipients	0	0	70	30
Adult dependents				
Of employees	50	0	50	0
Of working proprietors	0	0	50	50
Others	0	0	0	100
Children	25	10	15	50
Administration	0	0	0	100
All classes	25	10	15	50

they will be in proportion to their wage or income. The system seems very intricate and its worth cannot be judged until it has been placed in operation. Of the total governmental cost, 70 per cent would be borne by local governments. According to recent advices, the difficulties anticipated by local governments in raising 35 per cent of the entire cost presents an obstacle to acceptance.

Revenues for Medical Insurance in New York State

The Commission on Medical Care adopted the principles that in the event of enactment of a compulsory medical insurance plan for this State every resident should be covered, and in respect to financing:

Contributions should be in accordance with ability to pay. Everyone would benefit from sickness insurance and everyone should contribute according to his ability. That everyone may realize he is paying to the extent of his ability for service received, contributions should be clearly designated as for medical care. A material part of the cost should be met from a premium to be paid by everyone who has the means, based roughly upon what people now pay for care; in addition, a part of the cost should be borne by a tax on income, with an upper limit. No contribution should be required of employers. Localities should contribute for persons receiving public assistance. Funds required in addition to those realized from contributions should be derived from general tax revenues.

To determine how a tax plan might operate in keeping with these principles, data were collected bearing on a plan with the following characteristics:

1. An individual premium contribution by each eligible person over 17 years of age not dependent upon public assistance.
2. A flat-rate tax on income of residents of the State, and the earnings within this State of non-residents.
3. Payment by localities for persons receiving public assistance.

Dr. Clarence Heer, Professor of Economics and Commerce, University of North Carolina; and Mr. Ralph Burgess, (formerly Assistant to the Government Actuary, Division of Research and Statistics, U. S. Treasury Department; formerly Actuary, Joint Committee on Internal Revenue Taxation, U. S. Congress) Acting Director, Government Finance Department, National Association of Manufacturers; were employed to advise on a plan of this nature. In addition, Dr. Mabel Newcomer, Professor of Economics, Vassar College; Miss Selma Mushkin, Chief of the Social Insurance Section, Bureau of Research and Statistics, Social Security Board; and Dr. Chester Pond, Director of the Bureau of Research and Statistics, New York State Department of Taxation and Finance; were consulted less formally.

Individual premium contribution. In the words of the Commission's Committee on Finance:

It is characteristic of human behavior that what costs nothing to an individual is considered by him to be worth nothing, or very little. The value in a man's mind of anything is largely based on the effort which he must make to get it. For the State to provide free medical care to all of its citizens and to pay the cost out of the general revenues of the State is to make the citizen believe, first, that he always was entitled as of right to this service, and second, to make him unappreciative of what he receives and critical of the service to him and of its administration. The Commission feels that the principal factor in a sound social policy of State medical care is that the person who receives that care make, within his capacity, payment of some real part of its cost.

The purpose of an individual premium contribution would be three-fold. First, every adult not dependent upon the community would make some contribution in furtherance of the principle cited above. Second, there might be obviated the necessity of collecting very small amounts as computed as a percentage of income. Third, its employment in connection with registration of eligibility for benefits^{18/} would make it possible to collect at least a minimal amount from persons who might otherwise conceal sources of income and pay little or nothing. The individual premium contribution might be nominal in amount and chiefly for purposes of registration,^{18/} or it might be relatively large, bearing some relation

^{18/} A system of annual registration is indispensable in a State plan, especially in a State such as New York to which many non-residents come for medical care.

to the value of medical benefits available and serving as an important source of revenue. In the latter case it would be credited against income tax payments made or due, and would therefore be a minimum payment rather than a per capita tax.

The larger the premium, the more certain would be the collection of the full amount of the tax due from persons not subject to withholding of taxes from wages. In view of the millions of tax returns involved it would be difficult to check on understatements and omissions of income, especially in the lower income brackets, and inasmuch as a vast majority of wage earners subject to tax withholding would pay more than the premium contribution, relatively few families would be affected by the size of the premium, which might, Prof. Heer suggested, be set as high as \$12 per adult. Persons unable to pay the premium would have recourse to welfare departments for assistance. Although the size of the premium would be largely immaterial to welfare recipients and most of the income recipients, the low-income recipient liable to a minimum payment of \$24 per year for self and spouse might find it necessary to apply for public assistance, an undertaking which most people approach with reluctance. Premiums ranging from \$3 to \$7.50 have been suggested by others, with most of the qualified persons consulted believing that \$5 would be about the right amount, few if any self-supporting persons aged 18 or over being unable to meet this payment annually from their own resources.

There were 10 million persons over 17 years of age in 1940. Assuming that 0.4 million would be in receipt of public assistance in an average year,^{19/} and allowing an additional 0.3 million for persons not meeting a one-year residence requirement, inmates of mental and correctional institutions, etc., about 9.3 million residents aged 18 and over would be liable for payment of a premium or minimum payment.

Of this number, about 3.4 million would be unmarried and 5.9 million would be married persons.^{20/} All persons over 17 years of age might be required to register for themselves and their dependents under 18 years of age, and pay the premium (or minimum payment) individually, which would necessitate the filing of 9.3 million registration forms; or family heads might register for themselves, spouses (2.7 million), children 18-

^{19/} Annual reports of the State Department of Social Welfare list 406,901, 367,825, 301,555, 214,155 and 176,305 cases for the years 1940-44. A case may comprise several persons, the average being somewhat greater than one.
^{20/} 16th Census of the U. S., 1940, Population, Fourth Series. Actual figures for entire population aged 18 and over are 2,803,220 single, 851,540 widowed, 83,148 divorced and 6,303,860 married.

24 in private households and attending schools (0.16 million) and parents and other adult relatives in the household who are not self-supporting (0.2 million), as well as dependents under 18 years of age, which would necessitate the filing of about 6.3 million registration forms; or family heads might be permitted to register only for themselves, spouses, and dependents under 18 years, which would necessitate the filing of about 6.6 million registration forms. The latter procedure would seem best, because the income of other adult dependents should be subject to tax, and there might be legal, moral and practical difficulties in requiring one person to report and pay a tax for another who, although a dependent, was not a child or spouse.

Depending on the size of premium (or minimum payment) and the rate of tax on income, several million income recipients aged 18 and over would have incomes so low that income tax liability under the plan would be equal to or less than the individual premium contribution.^{21/} Since premium payments would be credited against income tax liability, no income tax would be due from this group.

The collection of individual premium contributions (minimum payments) has been considered feasible by the tax and income experts consulted. A vast majority of single persons and husband-wife units would have sufficient income subject to tax-withholding at the source so that the minimum payment would be less than, and would be covered by, the tax on income. Among the others, a powerful incentive to payment would be that eligibility for benefits would be contingent on registering and paying the minimum, or the total income tax liability, whichever was the greater. If a resident failed to meet this obligation it would ordinarily be a matter of only a short period of time before he required medical benefits and found that he could not obtain them under the insurance plan until current and previous obligations had been met in full.

Income tax. The tax proposed would be a flat rate on the income of all residents of the State, without any personal exemptions, deductions for dependents or the like. Non-residents would also be subject to the tax on income earned in the State because the medical program would be a general welfare measure contributing to the efficiency of the State

^{21/} At an income tax rate of 1.5 per cent and a premium of \$7.50, a single person with income less than \$500 annually would pay only the \$7.50 premium, and a married man and wife with any number of children would pay only the premium of himself and wife, \$15.00, if annual family income was less than \$1,000. With a 2 per cent rate and premium of \$5.00, single persons with income of less than \$250 would pay a minimum of \$5.00, family heads with income of less than \$500 would pay a minimum of \$10.00

from which they derived such income. Inasmuch as they would not be eligible for benefits, they should be allowed a personal exemption of an amount roughly equivalent to the actuarial value of the benefits to a single person - perhaps \$500 or \$600.^{22/}

Estimating the amount of income which would be subject to taxation is difficult because of uncertainty as to economic conditions in the future, and because no data currently available bear directly on New York State income at various levels. All available data, such as Federal estimates of income payments, Federal and State income tax returns, earnings covered by Unemployment Insurance and Old Age and Survivors Insurance, and the information on wages and salaries elicited by the U. S. Census of 1940, have been carefully examined and appraised, and opinions have been obtained from a number of persons qualified in the field of income prediction. Table 7 shows income payments over a period of years as reported by the United States Department of Commerce.^{23/}

Table 7. Income Payments (in Millions) New York State, 1929-44^{23/}

Year	Salaries & wages	Other income	Total
1929	\$8,699	\$5,348	\$14,047
1932	5,332	3,764	9,096
1933	4,843	3,586	8,429
1938	6,355	4,235	10,590
1940	7,460	4,370	11,830
1941	8,754	4,630	13,384
1942	10,330	4,802	15,132
1943	12,271	5,273	17,544
1944	13,354	5,991	19,345

The experts consulted are of the opinion that 1943 best typifies the postwar years in view of current trends and plans for the postwar economy. Prof. Heer estimated postwar annual income payments at \$16,400 million, Prof. Newcomer estimated \$15,000 to \$17,000 million, Mr. Burgess' prediction was \$15,600 million, and Dr. Hildegard

Kneeland of the United States Bureau of the Budget estimated an income similar to that of 1943 (\$17,500 million).

It seems reasonable to assume that income payments as defined by the United States Department of Commerce will be about \$16,000 million annually for the postwar decade. However, not all of this would be taxable. Allowances must be made for institutional interest (i.e., interest accrued to insurance companies, banks and institutions, but not currently paid out to individuals), labor income other than wages, non-cash farm income, military pay, pensions, social security payments, compensation for illness and injury, and underreporting. It has been necessary to

^{22/} As under the personal income tax law, residents of States imposing a tax on their residents for equivalent purposes would be exempted upon agreement between New York and the other States.

^{23/} Monthly Labor Review, U. S. Department of Labor, January 1941, Survey of Current Business, U. S. Department of Commerce, June 1943 and August 1945.

employ the years 1941 and 1942 for detailed estimates of the tax base and related factors because insufficient data are available for subsequent years. In 1941, income reported on Federal income tax returns represented 62 per cent of total income payments; in 1942, the corresponding percentage was 66. In 1941, more than 70 per cent of the total of income payments was taxed, either under the Federal income tax or Old Age and Survivors Insurance, or both. The social security taxes did not, however, reach incomes received by the self-employed, by public employees, by farmers and farm laborers, domestic servants, railway employees, and by persons deriving their support from annuities and investments, and the Federal income tax did not reach incomes below \$750 for single persons and \$1,500 for married couples. All of the income categories enumerated above would be subject to taxation under the proposed revenue plan. Moreover, to the extent that the proposed tax would be collected in large part at the source, whereas the 1941 Federal income tax was not, there should be a smaller degree of evasion.

The income that would be subject to taxation is estimated in Table 8 for the year 1941. It appears that \$11,600 million, or 87 per cent of

Table 8. Estimated Net Income Base Without Personal Exemptions, New York State, 1941^{24/} (in millions)

Total income payments	\$13,384
Adjustments (total)	1,144
Labor income other than wages	592
Non-cash farm income	41
Military pay	35
Institutional interests <u>a/</u>	476
Gross tax base	12,240
Adjustment for underreporting <u>b/</u>	612
Tax base without exemptions	11,628
Less income over \$5,000	1,433
Tax base excluding income over \$5,000	10,195

a/ Represents 40 per cent of total New York State interest payments.

b/ If taxes on wages are withheld at source, underreporting may be held at 5 per cent; a larger allowance does not seem warranted.

income payments would be subject to a tax without an upper limit. \$10,195 million, or 76 per cent would be subject to a tax limited to the first \$5,000 of income. For the same period, Dr. Pond has estimated that \$9,600 million, or 72 per cent of total income payments would taxable under a \$5,000 income limit, and Dr. Heer states that 70 per cent of total income

^{24/} From data furnished by the technical staff, Bureau of Research and Statistics, Social Security Board.

payments under the \$5,000 limitation, and 80 per cent of total income payments if the \$5,000 limitation were removed, would be conservative figures. Inasmuch as income from wages and salaries, and proprietors' income, have risen more rapidly from 1941 to 1943 than income from property and other sources, it may be assumed that in a typical postwar year with income payments of \$16,000 million, the percentage under \$5,000 would be relatively less than in 1941. In view of the present uncertainties surrounding wage levels, etc., it has not been deemed profitable to attempt further refinements of estimates. It seems reasonable to assume that 75 per cent of the estimated \$16,000 million postwar income, i.e., \$12,000^{25/} million would be subject to a tax applying to the first \$5,000 of income. \$14,000 million, or 87.5 per cent of the total postwar income, would be taxable if there were no upper limit.

There is no wholly adequate method of estimating the amount of income and number of taxpayers in various income classes. Table 9 shows the distribution of income and of taxpayers in 1942, the most recent year for which Federal income tax data are available. The data are limited in that returns were required only on incomes of \$750 and over for single persons and \$1,500 and over for married persons, thus excluding a large amount of income below these levels.^{26/} Also, incomes may be somewhat understated because withholding of tax from wages and salaries was not in effect in 1942. Other sources of data are Old Age and Survivors Insurance, Unemployment Insurance, and U. S. Census statistics. Since the former two are very similar and the latter applies to 1939 income, only the Unemployment Insurance figures for 1942, the year corresponding to the Federal income tax figures, are shown in Table 10. Because these data are limited, applying only to wages and salaries, classifying only income groups under \$3,000, and reflecting only earnings in covered employment, they are presented primarily for the purpose of indicating roughly the distribution of persons and earnings under \$1,500.

A system of withholding taxes from wages and salaries is necessary for efficient tax collection, it being unofficially estimated that with-

^{25/} Prof. Newcomer estimated about \$12,000 - \$12,500 million, which checks fairly closely with that of Miss Mushkin. Prof. Heer has estimated that the amount would be more than \$11,200 million.

^{26/} Another limitation is that because of the progressive income tax rate, there is an incentive to the filing of separate returns by husband and wife, where both have income. This tends to increase the number of returns and to throw them into lower brackets than would be the case if all returns were on a joint return basis for husband and wife.

Table 9. Distribution of Net Income^{a/} in New York State in 1942, by Income Levels, as Reported by Individuals on Forms 1040 and 1040a and by Fiduciaries on Form 1041.^{27/}

Income	Form 1040	Form 1040a	Form 1041	Total	
				Amount	Per cent
	Net income in 1000's of dollars				
Under \$750	\$ 150,131	(\$)	\$1,758	(\$)	()
750-999	188,355	(813,764)	884	(1,802,308)	(17.94)
1000-1499	645,638	()	1,768	()	()
1500-1999	933,357	690,939	1,768	1,626,064	15.19
2000-2499	913,571	579,402	1,326	1,494,299	14.87
2500-2999	796,082	357,180	1,326	1,164,588	11.59
3000-3999	1,081,504	0	2,210	1,083,714	10.79
4000-4999	500,527	0	1,768	502,295	5.00
5000-9999	745,946	0	6,591	752,537	7.49
10,000-19,999	567,411	0	6,591	574,002	5.71
20,000 or more	1,028,587	0	18,203	1,046,790	10.42
Total	7,551,109	2,451,285	44,203	10,046,597	100.0
First \$5,000	6,083,995	2,451,285	22,413	8,557,693	85.18
First 10,000	6,602,451	2,451,285	28,429	9,082,165	90.40
First 20,000	6,988,982	2,451,285	33,680	9,473,947	94.30
Number of returns					
Under \$750	284,791	()	4,990	()	()
750-999	214,332	(794,315)	1,151	(1,814,256)	(40.74)
1000-1499	513,142	()	1,535	()	()
1500-1999	535,522	398,122	1,024	934,668	20.99
2000-2499	408,902	260,515	640	670,057	15.05
2500-2999	290,946	134,475	512	425,933	9.56
3000-3999	317,638	0	639	318,277	7.15
4000-4999	112,931	0	384	113,315	2.54
5000-9999	110,232	0	1,017	111,249	2.50
10,000-19,999	41,411	0	518	41,929	.94
20,000 or more	23,323	0	384	23,707	.53
Total	2,853,170	1,587,427	12,794	4,453,391	100.0

a/ Does not allow any personal exemptions, credit for dependents, allowance for contributions, or earned income credit allowable for purposes of computing the income subject to Federal tax. Business expenses excluded.

out such a system nearly 20 per cent of potential revenues may be lost.

On the basis of the 1942 data shown in Table 11, it appears probable that 90 per cent of salary and wage income would be affected by a withholding tax, and that at least 80 per cent of all taxable income would be subject to it. Prof. Heer predicts that the greatest difficulty in tax collection will center around a group of about one million persons who are employers and own-account workers, farmers and farm laborers, domestic servants and persons not in the labor force, whose compliance with the tax requirements would be difficult to check. Whether these individuals will register and pay the premium or income tax will depend upon their estimate of the worth

^{27/} Derived from Statistics of Income for 1942, Part 1, U. S. Treasury Department, Division of Internal Revenue, and unpublished data obtained from the Division of Internal Revenue.

Table 10. Distribution of Employees and of Earnings in Employment Covered by Unemployment Insurance, New York State, 1942 ^{28/}

Income group	Distribution of employees ^{a/}		Distribution of earnings	
	Number	Per cent	Amount	Per cent
0-\$499	1,832,000	31.6	331,051	4.3
500-999	1,038,000	17.9	740,750	9.7
1,000-1,499	940,000	16.2	1,099,175	14.4
1,500-1,999	679,000	11.7	1,108,359	14.5
2,000-2,499	429,000	7.4	902,979	11.8
2,500-2,999	354,000	6.1	921,341	12.0
3,000 or more	528,000	9.1	2,550,979	33.3
Total	5,800,000	100.0	7,554,534	100.0

^{a/} Estimates, based on representative sample.

of the medical protection afforded in comparison with its cost to them. This is not a new problem with respect to taxation of income and one would

Table 11. Distribution of Estimated Wages and Salaries ^{a/} Paid in Specified Employments, New York State, 1942 ^{29/}

Type of employment	Per cent
Employment covered by OASI	77.0
Railroad employment	2.8
Government employment	11.7
Domestic service	1.9
Agriculture	0.7
All other	5.9
Total	100.0

^{a/} Represent \$10,788.5 million in wages and salaries paid in cash and kind, within continental U. S., including pay to armed forces.

not expect poorer compliance than under present State and Federal income tax laws; in fact, a powerful incentive to paying the tax lies in the value of medical benefits which cannot be obtained otherwise. It would be expected that very few people would fail to register, the problem rather being to assure the statement of all

taxable income.

In order that overwithholding of taxes from wages and salaries would be held to a minimum, and that, as described in the discussion of administrative features, deductions might be allowed in consideration of premiums paid to private medical insurance plans, it has been suggested by Mr. Burgess that the withholding rate be fixed at one-half of the total tax rate. For the accumulation of an initial reserve, a tax at the withholding rate might be imposed for a year prior to making benefits available^{30/} or, as preferred by Prof. Heer, the initial registration would carry a fee of \$2, which would start off the system with an initial reserve of about \$18 million, and benefits would be available immediately upon registration.

^{28/} From data supplied by Bureau of Research and Statistics, Division of Placement and Unemployment Insurance, New York State Department of Labor.

^{29/} Social Security Yearbook, 1942, Social Security Board, Washington.

^{30/} In inaugurating Unemployment Insurance in this State, a tax at a low rate was imposed for a period of two years prior to offering benefits.

In respect to obtaining revenues on behalf of public assistance recipients and other persons unable to pay the minimum (individual premium contribution) for themselves, three methods are available. First, welfare districts might pay a premium bearing a close relation to the per capita cost of benefits offered under the medical program, inasmuch as they would be relieved of equivalent expenditures. Under such a system they could readily receive State and Federal reimbursement of some of the moneys thus paid out. Second, in consideration of the present expenditures from which they would be relieved, the localities might be assessed on the basis of total population or assessed value of real estate, or on the basis of accustomed public medical expenditures. Assessment on the basis of general population or assessed valuation would seem desirable because it would be based upon the ability of localities to pay, and on the cost of meeting the actual medical needs of indigent persons rather than what the localities were accustomed to spend. Either method has the virtue of stabilizing the obligation, rather than basing it upon a fluctuating relief load which would require the greatest local expenditures at a time when economic conditions were poorest. Under this method, no additional expenditures would need to be made by the localities, certification of eligibility for medical benefits being issued simply upon recommendation by the public assistance agency.

In view of the present State-local system of tax sharing, and that of reimbursement for welfare costs (which may soon result in the State bearing a much larger share than it now does), both methods would perpetuate a real estate tax on properties already over-burdened, and with respect to State participation would result in the State collecting taxes, paying them over to the localities, and in turn receiving them back from the localities without the advantage of local administration which is the heart of the system as practiced for other purposes. A third method, proposed by Prof. Heer, would be for the State to collect and administer funds for medical care directly, without any obligation on the part of the localities beyond possibly the payment of the registration fee (minimum tax, or individual premium contribution) for the indigent. To compensate for the loss of income from local sources, the proposed \$5,000 ceiling on the income tax should be raised or, in Prof. Heer's opinion, abolished.

Other sources of revenue. A reasonably comprehensive medical care program would cover a majority of the medical services now provided pur-

suant to the Vocational Rehabilitation Law, Physically Handicapped Children's Law, etc., from public funds subject to State and Federal financial participation. In the interest of efficiency and economy of administration, legislative sanction should be given to such agencies to furnish medical care to their clients through the facilities of the State medical insurance agency. Suitable payment therefor could be made to the State medical administrative agency on a per-service, per-case or per capita basis, and the State would continue to enjoy Federal financial aid for the medical care aspects of such programs.

The medical program should also be authorized to provide benefits to veterans at Federal expense, waiving an amount of tax equal to the moneys paid by the Federal Veterans Administration, and to receive any Federal moneys that might become available in aid of a general medical care program, insurance or otherwise.

CHAPTER XXIII

ADMINISTRATION AND RESEARCH

The administration of a medical insurance plan should have efficiency and economy of operation as an objective, but there should not be overlooked the possibility that the efficiency and economy appearing on the records of the administrative agency might have been achieved only at the price of wasteful expenditures of time and effort by those receiving and providing services, and of a vast number of irksome applications, authorizations and appeals necessitated by a misguided passion for economy, rather than for the fulfillment of the broad objectives of the program. Every effort should be made to avoid needless paperwork and tedious negotiations. Although the operation of the plan should be guided by written rules and regulations, ample opportunity should be provided for discretionary action within this framework.

Administrative Agency

The general administration of a compulsory medical insurance plan may be vested in any one of a number of governmental agencies;—public health, labor, welfare, or an independent department, or different functions may be distributed among various departments of health, taxation, labor, insurance, etc. Because medical insurance involved the many diverse functions of medical, dental and other professional supervision, insurance, taxation, etc., it would seem desirable that administration should be by a single independent agency capable of discharging a majority, if not all, of these functions.

At the beginning of an insurance program there is a need for administration with vision and boldness, unhampered by the restrictions and traditions which have often grown up in long-established departments. The administrative and regulatory patterns for a new undertaking should be developed to conform with needs rather than established practices. To provide the necessary flexibility in the early stages of the program, an independent agency would seem to be best, although after an initial period during which suitable administrative patterns and principles were evolved, such agency might be amalgamated with an existing department.

Policy-Making

In some plans, policy determination as well as executive powers would be centered in one person who might, but would not be required to, seek the guidance of an official advisory group. In other plans, both executive

and policy-making powers would be the responsibility of a small board composed of persons devoting full time to such duties. A type of organization which is also employed and which would seem best suited to the needs of a medical insurance program would vest policy-making powers in a board appointed by the chief executive of the State. Such board would have no administrative or executive powers, but would be authorized to enact regulations clarifying and implementing the broad statutory provisions of the insurance plan, and to advise the executive on matters which he would place before them.

Composition. The interests of persons receiving and persons providing service should be recognized, but should not be paramount in determining the composition of the policy-making board. To afford representation to every group in accordance with numerical and other indications of their importance would necessitate a board so large as to be extremely unwieldy. The members of the board should be selected with a view to their ability to gauge the needs of the people apart from their own personal or professional concerns but should, at the same time, have sufficient professional background to be appreciative of technical matters. To achieve this objective it would seem desirable to have a board of, say, 11 members: 5 representing the public at large, 5 representing the professions (2 physicians, 1 dentist, 1 hospital administrator, 1 nurse), and the eleventh being the executive of the medical insurance agency.

Official advisory committees. To obtain competent advice on technical matters, provision should be made for official committees advisory to the executive and to the board. The committees should be appointed by the executive with the advice and consent of the board. These committees should include, but should not be limited to, medicine, dentistry, nursing, hospital care, public education, research and insurance.

Regulations. The regulations of the board should be consistent with and should have the force and effect of law, subject to review by the courts as to their reasonableness.

Executive

The executive of the public medical insurance agency might be appointed by the board, or by the chief executive or by a ranking officer of the government. Although there is much to be said in favor of either method, it would not seem consistent with the function of the board to have the executive appointed by it. Differing views have been expressed as to whether the executive should be a physician or layman. It would seem best to leave

this matter to the decision of the appointing officer. It should be required only that the executive be a person of proven administrative ability, but it should be stated for the guidance of the appointing officer that preference should be given to a physician so qualified."

Appointive powers. The executive should be granted full power to appoint his deputies and all subordinate personnel. The powers of the board in this respect should be limited to establishing qualifications for personnel at the higher levels.

Central administrative divisions. Divisions of medicine, dentistry, hospital care, nursing, finance, research and statistics, public education and administration should be provided for by statute and the qualifications of their respective directors broadly indicated for the guidance of the board and executive.

Local Administration

Delays, red tape and conflicting decisions are all too often associated with, although they are not peculiar to, public administration. They are not necessarily inherent in public administration and can be avoided through the proper administrative pattern and the selection of capable administrators vested with adequate authority. Prompt payment for services rendered, prompt and authoritative decisions on questions arising from interpretation of regulations, and prompt adjudication of disputes are most necessary to smooth and efficient administration. These objectives can be accomplished through decentralization of administration so that the district offices of the insuring agency have ample authority within the framework of generally applicable rules and regulations.

This authority should be granted in such fashion that an honest or reasonable interpretation of regulations by the district office in any individual case will not be subject to change by the central office; otherwise, confusion and mistrust may be engendered in those receiving and those providing service. For example, if the district office should approve a certain service as being a benefit under the plan, such decision should stand despite a differing interpretation that might later be rendered by the central office. The physician or hospital providing the service, or the beneficiary, should not bear the cost or burden of a service provided or received with the approval of the district office and later disapproved by the central office. The remedy for any persistent or flagrant disregard of regulations should lie in further clarification of regulations or disciplinary action. Beneficiaries and those rendering service should be

permitted to appeal to a local district board from the decision of the district administrator.

Local administrative districts. To facilitate decentralized administration, the State should be divided into districts with local administrative organizations roughly similar to the central organization. The flow of authority should be directly from the State executive to the district administrator, the directors of the central administrative divisions channelling their recommendations or orders to the districts through the State executive.

Local administrative officers. Local district administrative staffs should include physicians, dentists, nurses, etc., to insure that professional persons rendering service have the opportunity to discuss their problems with professional persons thoroughly familiar with the field.

Local advisory committees. To advise the district administrator there should be in each district an official local advisory committee appointed by the State executive. The committee should be in composition similar or identical to the central policy-making body. The local committee should be advisory to the district administrator and to the State executive, and it should be authorized to hear appeals from the decisions of the district administrator. The committee should not have policy-making, executive or administrative powers, but should have the right to transmit copies of its proceedings or resolutions to the State executive.

Budgetary and Financial Practices

Sound budgetary principles should be followed, with statutory fixation of the amounts to be allocated for administrative and related purposes. Disbursements by properly deputized local administrative officers should be authorized to assure prompt payment of claims. In respect to pro-rating of payments to physicians, dentists, etc., providing care on an indemnity basis, it would seem desirable to avoid delayed payments or refunds by arbitrarily fixing the rate for the first year of operation, and by employing in subsequent years a rate determined by the previous year's experience.

Administrative Controls

Some instances of excessive use or of misuse of service are inevitable under any medical insurance plan, voluntary or compulsory. One of the greatest hazards under voluntary plans lies in an unfavorable selection of risks, a problem which does not have to be faced by a plan covering an

entire population group.

Several factors should be borne in mind in developing administrative controls. The first is that, in general, beneficiaries are not entirely without individual financial resources and that although a plan should aim to provide complete service within the categories of benefits specified, the situation of beneficiaries as it exists today would not be worsened by failure to provide certain benefits, e.g., drugs, which promised to be difficult to control administratively. The second is that in an endeavor to correct abuses by the small proportion of persons who will perpetrate them, the majority should not be subject to unduly strict regulation. Third, as far as possible, the controls should operate automatically and unobtrusively. Some of the controls that might be applied to hospitalization have been described in Chapter XXI. The system of automatic control which has been developed in Essex County, Ontario, although not directly applicable to an insurance plan, indicates what might be accomplished by a scientific approach to the problem of controlling home and office visits.^{1/}

Participation by Private Plans

As shown in Table 4 of Chapter XV, a majority of national plans administer health insurance through "approved societies." The ostensible objective of permitting administration of a public function by private groups seems to have been to place local control in the hands of the beneficiaries. It has also been thought that persons receiving benefits through such groups would receive a more personal, individual service than through public "bureaucratic" administration. However, the great weight of evidence tends to show that administration through private plans does not result in actual control by the beneficiaries (apparently because of apathy of beneficiaries rather than factors inherent in the organizations), and that, ordinarily, private administration is quite as soulless and restricted by regulation as is public administration. Other objections to administration by private agencies seem to be that administrative costs are relatively higher than those experienced under public administration, that benefits and risks are not uniform from plan to plan (except where administered on a topographical basis), and that confusion is introduced by a multiplicity of private agencies.^{2/3/}

^{1/} Medical Relief Administration, N. Sinai, M. F. Hall and R. E. Holmes, Essex County Medical Economic Research, Dominion Office Supply Co., Windsor, 1939.

^{2/} National Health Insurance, Hermann Levy, University Press, Cambridge, 1944.

^{3/} In England, 7,000 private agencies participate in administering health insurance for 19 million beneficiaries.

The fact that many national systems provide for the participation of private plans seems to be based on the simple fact that they have preceded the compulsory plans and that popular sentiment and the self-interest of those concerned have dictated their continuance. In addition, it has seemed almost a necessity that private plans be permitted to participate if the benefits offered by the compulsory plan are limited, because the private plans thus afford an opportunity to obtain additional benefits on an insurance basis to those who wish them and can afford them. On the other hand, participation by private plans may serve to retard or prevent the provision of more comprehensive benefits to needy segments of the population. It should be remarked, however, that the objections to participation by private plans are not as marked if they are placed in competition with a strong publicly-administered plan.

Despite the arguments against participation by private plans, only a few nations, such as New Zealand, have seen fit to eliminate them at the time of adoption of compulsory insurance.^{4/} Because voluntary plans have become firmly established in New York State, it would seem best to provide for their participation, guarding as well as possible against the abuses and uneconomical practices which have been experienced elsewhere. It is visualized that under a revenue system providing for contributions by beneficiaries only, a mechanism would be provided whereby employees and employers might independently arrange for the equivalent of employer contributions. In addition, the participants in private plans would be free to arrange systems of remuneration of physicians, dentists, hospitals, etc., (e.g., clinic practice, salaried or capitation practice, inclusive hospital rates, etc.) which would be mutually satisfactory and which would result in savings to the beneficiaries thus covered. The system outlined below would seem to solve most of the vexatious problems, except that of selective enrollment. The private plans would tend to cover population groups with health risks more favorable than those prevailing in the general population. Under the method outlined, the private plans would have to stand on their own resources because no public subsidy would be afforded.

^{4/} Senator Wagner is quoted as saying, in introducing S.1050, that all qualified organizations - Blue Cross plans, and medical service organizations created by unions, consumer-organizations, employers, medical societies, etc., would be able to participate in the national medical insurance system, furnishing services to the insured persons who choose them, receiving fair payments for services furnished, and having enlarged opportunities to be service agencies for their respective groups. (Journal of the American Medical Association, 128:372, June 2, 1945). S.1605 also provides for participation by private groups. Presumably, these groups would derive their income from payments made to them by the government insurance agency.

Perhaps the most objectionable feature would be that because of their flat-rate premiums, subscribers to private plans would be chiefly persons and families of above average income, which might possibly introduce a class-distinctive feature.

Approved private plans. Any organization licensed under the State Insurance Law for the purpose of providing medical and/or hospitalization insurance, and any organization which had as one of its purposes the provision of medical care to its members but which was specifically exempted by the State Insurance Law from licensure requirements, could apply to the public insurance agency for approval as a private plan for the purpose of participating. The application should set forth in detail, data in respect to the coverage to be afforded, benefits to be offered and other pertinent information. Upon satisfying itself that the purpose for which approval was requested was in the public interest and in conformity with the publicly-administered plan, a certificate of approval would be issued by the public insurance agency.

Conditions for approval. To be approved, private plans should meet the following minimum conditions:

1. Enrollment of beneficiaries as a family unit.^{5/}
2. Benefits should include as a minimum either medical practitioner benefits, x-ray diagnostic and radiotherapy benefits, and clinical laboratory benefits; or dental benefits; or hospital benefits; or a combination thereof, the content of the individual benefits to be at least as great as those required in the publicly-administered plan.
3. Payment should be made to the person or organization rendering care (but the rates of payment would not need to conform to the unit fee schedule of the publicly administered plan).
4. The face of the certificate of enrollment should state clearly the amount which was determined by the State agency as that which might be claimed as a waiver of tax liability.
5. Each plan should agree promptly to notify the State agency of enrollments and withdrawals of beneficiaries.

Tax waiver determination. The executive of the State agency should prepare a schedule of amounts to be allowed beneficiaries as deductions from tax liability in consideration of their enrollment in a private plan. In preparing the schedule the State executive should request the approved private plans to submit statements of the amounts considered by them as reasonable allowances for the benefits furnished, and he should consult his official advisory committee on insurance, but he should also give consideration to the views of others. In no event should the scheduled allowances be greater than the cost of providing equivalent benefits to

^{5/} For suggested definition of family unit, see proposed legislation for medical and dental groups, Chapter XXI.

beneficiaries under the public plan, due regard being had to the factor of selective risks and administrative costs.

Public Education

To realize the potential benefits in a medical care program the public should be taught to use it properly. Any increase in the volume of services provided should be appraised from the standpoint of needs and accomplishments and should not be condemned without reason as excessive use or misuse of benefits. The public should be educated to seek medical care promptly and to the necessary extent. Educational methods should be used in preference to administrative methods for the purpose of discouraging unnecessary use of services. Emphasis should be placed on the use of benefits for early diagnosis and treatment, and for the prevention of disease and disability.

Research

Continuous improvement of a medical insurance program should be sought through researches for the purpose of developing and simplifying administrative methods, and for determining medical needs and the extent to which they were met by the program. Although researches in the medical sciences should continue to be carried on independently by institutes for higher learning and research organizations, the medical insurance agency should, with the advice of appropriate official committees, make grants to such institutions for general and specific studies. It would seem desirable that provision for research funds should be made in the annual budget of the insurance agency, within upper and lower limits fixed by statute.

CHAPTER XXIV

SUMMARY

1. The objectives of the Commission have been to determine the volume and cost of care furnished by public and private agencies, to study the methods which are and which might be employed in providing care, and to make proposals for improved methods of providing medical care.

2. The need for medical care exists universally; there is evidence that the absolute need is approximately the same in New York State as in the nation. The amount of care needed is somewhat greater for low-income than for high-income groups. A lack of adequate medical care tends to produce poverty and financial dependence, which in turn tend to produce a relatively greater need for care, thus establishing a vicious cycle.

3. The amount of medical care received on the average varies not with need, but with ability to pay for it, with the exception of persons largely or completely dependent upon the public for subsistence. The disproportionately small amount of medical care received by persons of below-average income requires a disproportionately large percentage of their income. This disproportion is emphasized rather than relieved by voluntary insurance programs because their premiums are fixed without regard to ability to pay. The purchase of medical insurance at uniform rates, i.e., at the average cost, is beyond the financial capability of a large proportion of the population. The attempt of private persons and agencies providing medical care to adjust charges to ability to pay tends to but does not in satisfactory measure relieve the disproportionality mentioned.

4. The public medical care programs in the State generally provide care only to persons whose income affords a standard of living below or close to a subsistence level. With the possible exception of hospitalization and certain health supervisory services, the public programs offer little to persons below average income but above a subsistence level.

The hospitalization of tuberculous and mental patients is in the public interest and may be required by legal process, but the public has not fully met its obligation to provide such hospitalization as a wholly public responsibility.

5. The provision of medical care to the population as a whole in accordance with medical needs would seem to be limited to three methods:

Care at public expense to those who qualify under a means test.

Care at public expense from general funds for all persons, regardless of financial ability.

Care at individual expense on a compulsory insurance basis, with required payments graded according to financial ability.

The first method does not seem acceptable, because to apply for care by public charitable agencies is generally distasteful and is not practiced except in emergencies or periods of great financial stress. People prefer to obtain medical care through payments from their own resources.

The second method is not recommended, except for certain specialized services such as hospital care of tuberculosis and mental disease, because it may lead to the provision of all care by physicians, dentists and hospitals in the direct service of the State, and to reliance of the people on the State rather than their individual resources.

The third method seems to be the most desirable and the one in greatest public favor.

6. A majority of the people of the State believe in the purchase of medical care by insurance methods. Voluntary medical care and hospitalization insurance plans are generally available, but many persons and families find themselves unable to pay premiums, and many others encounter difficulties in enrolling, due to occupation, place of employment, age, physical condition, etc. Some persons otherwise eligible do not enroll in voluntary plans because of indifference to their own needs and the needs of children and others who may be dependent upon them.

7. The provision of medical care in accordance with medical needs can be accomplished only if persons of above-average income contribute on behalf of persons of below-average income. To achieve this it is necessary to compel payments, either in the form of general taxes or personal contributions graded in accordance with ability to pay. A majority of the people of the State favor, and it is feasible to establish a compulsory plan under which the amount of the payments would depend on individual or family income, and which would cover everyone, with each self-supporting person making his own payments.

A reasonably comprehensive plan would require payments of between 3 and 4 per cent of income. Payments on this scale would not be much greater than the present average, because there would be added only the average cost of the additional service provided.

8. The income of the people of the State of New York is adequate to pay for, and the State possesses personnel and facilities sufficient to implement an insurance plan covering all persons for physician and hospital

care. Dental personnel are insufficient to implement any but a limited program. The experiences of voluntary and compulsory medical insurance plans indicate that there may be developed an administrative system which would preserve the freedom of action of those providing care and those receiving it.

PART 3

SURVEY OF NEW YORK STATE PUBLIC OPINION ON MEDICAL INSURANCE

A Report To The New York State Commission On Medical Care

From SURVEYS INCORPORATED, New York and Washington, February 1946

Foreword

The following reports the results of a survey of New York State public opinion made in January 1946 by Surveys Incorporated for the New York State Commission on Medical Care. Experienced field reporters personally interviewed 2,500 persons in a representative sample (cross-section) scientifically covering the adult population of New York State. The identity of the organization for whom Surveys Incorporated operated this opinion research was not made known to the persons interviewed or to the field reporters.

The questions asked in the survey are reproduced verbatim in the tables of this report. The sample was prepared under the supervision of Dr. Raymond Franzen, New York statistician who serves as consultant to leading industrial and governmental organizations of the nation.

In the preparation of this survey and particularly the questionnaire, Surveys Incorporated had as consultants Dr. Franzen and Mr. Lawrence E. Benson, one of the heads of Benson & Benson, Inc. of Princeton, New Jersey, and long identified with one of the best known public opinion research organizations in the country.

Surveys Incorporated also received the benefits of the advice of Mr. Harry H. Field, Director of the National Opinion Research Center of Denver, Colorado, Mr. Stanley Payne, Opinion Research Corporation of Princeton, New Jersey, Mr. John P. Hunt of Chicago, Illinois, identified with the recent medical care survey of Michigan, Mr. John R. Little of Los Angeles, California, identified with the recent medical care survey of California, and Mr. Homer N. Calver of New York City, Director of Health Exhibits of the 1939-40 New York World's Fair.

... Summary of Findings

86.0 per cent of the adult population of New York State think that everybody who lives in the State "should have insurance which pays doctor and hospital bills". When asked which one of two ways to pay doctor and hospital expenses they think is better, 70.3 per cent prefer "making regular payments for insurance that will pay doctor and hospital expenses as they come up" and 22.9 per cent prefer "paying doctor and hospital expenses as they come up".

Choosing between two methods for doctor and hospital insurance, 51.9 per cent prefer "a plan under which the amounts of your insurance payments would depend on the amount of your family's income - everybody would have to contribute to it - and it would be handled by the government". On the other hand, 35.6 per cent prefer "a plan under which the amounts of your insurance payments would be the same as for everybody - anyone could join or stay out - and it would be handled by a non-governmental group".

Those who preferred the government insurance plan were asked which government they thought should handle it. 48.4 per cent prefer the Federal Government. 32.6 per cent prefer the New York State Government. 18.5 per cent don't know. Those who preferred the nongovernmental insurance plan were asked which of the following they thought should handle it: insurance companies, doctor groups, employers, unions, or others. 59.9 per cent prefer insurance companies. 14.6 per cent prefer doctor groups. 11.1 per cent don't know. 7.2 per cent prefer employers. 2.9 per cent prefer unions.

If a doctor and hospital insurance plan is put into effect in this State, 85.4 per cent think "it should cover everybody", 6.5 per cent think it should cover "just those people who work for business and industrial companies", and 8.0 per cent don't know. If such a plan is put into effect in this State, 52.8 per cent believe it "should cover everybody, with each person making all his payments for it". 33.7 per cent believe it "should cover just those people who work for business and industrial companies, with one-half of their payments being made by the workers themselves and one-half by their employers". 13.1 per cent don't know.

63.1 per cent think "the plan should also pay to employed workers about one-half of their usual earnings during the time they are not able to work because of illness or an accident - and for this the insurance payments from employed workers would be increased, according to the amount of their earnings". 17.8 per cent opposed this, and 18.7 per cent don't know.

68.7 per cent do not "have insurance which pays money during sickness or disability (including accidents), money that you can use any way you want". 28.0 per cent have such insurance. 49.7 per cent of those with such insurance do not know how much the insurance costs. 55.2 per cent with such insurance report that it covers one person.

53.1 per cent report that no members of their immediate families "have insurance or belong to a hospital plan which pays the hospital for all or part of the hospital bills". 44.4 per cent report that they do have such insurance. 30.5 per cent of those having such hospital insurance do not know its cost. 74.0 per cent report that no part of this hospital insurance is paid for by an employer. One person is covered by the hospital insurance of 22.1 per cent of those with such insurance, two persons of 28.0 per cent, three persons of 18.7 per cent, and four persons of 16.9 per cent.

25.1 per cent report that they or some members of their immediate families have "received hospital treatment during the last twelve months". 79.8 per cent declare that they or some members of their immediate families have "had to see a doctor during the last twelve months".

87.8 per cent state that neither they nor any members of their immediate families "have insurance which pays the doctor for all or part of the doctor bills". 9.8 per cent say that they do have such insurance. Of those who do have such doctor insurance, 40.2 per cent do not know how much it costs. 62.3 per cent report that no part of such doctor insurance is paid for by any employer. One person is covered by the doctor insurance of 38.1 per cent of those with such insurance, two persons of 21.9 per cent, three persons of 14.6 per cent, and four persons of 14.4 per cent.

The questions and the responses, in total and according to residential, sex, age, economic and voting groups are shown in the tables of results.

ATTITUDES ON MEDICAL INSURANCE GENERALLY

Question: Do you think everybody who lives in New York State should have insurance which pays doctor and hospital bills?

<u>Response</u> (per cent):	<u>Yes</u>	<u>No</u>	<u>Don't know</u>
TOTAL	86.0	7.7	6.3
<u>Residential groups</u>			
Rural non-farm	80.4	17.2	2.4
Farm	80.7	15.9	3.4
City and village	86.6	6.4	7.0
<u>Sex groups</u>			
Male	86.0	8.5	5.5
Female	86.0	6.9	7.1
<u>Age groups</u>			
21-29 years	89.3	6.1	4.6
30-39 years	87.7	6.8	5.5
40 years & over	84.2	8.6	7.2
No information given	49.6	25.2	25.2
<u>Economic groups*</u>			
Under \$30 a month rent	77.0	10.2	12.8
\$30 - 39 a month rent	84.8	8.7	6.5
\$40 - 49 a month rent	89.1	4.2	6.7
\$50 - 74 a month rent	83.2	11.3	5.5
\$75 - 99 a month rent	85.6	10.4	4.0
\$100 and over a month rent	82.3	12.4	5.3
No information given	80.0	10.0	10.0
<u>Voting groups</u>			
Voted for Roosevelt, 1944	90.2	4.9	4.9
Voted for Dewey, 1944	81.2	12.5	6.3
Others	83.6	8.5	7.9

*Actual monthly rental, or equivalent in home ownership.

COVERAGE BY CASH SICKNESS BENEFITS

Question: Do you or does any member of your immediate family have insurance which pays money during sickness or disability (including accidents), money that you can use any way you want to?

Response:

Yes	28.0 per cent
No	68.7
Don't know	3.2
No information	<u>0.1</u>
Total	100.0

Question: (addressed only to those who have cash sickness benefit insurance): How much does this insurance cost you or your family?

Response:

Under \$1.00 per month	4.9 per cent
\$1 - 1.99	10.4
\$2 - 2.99	14.2
\$3 - 4.99	9.3
\$5 and over	10.1
No figure given	0.9
Nothing	0.1
Don't know	49.7
No information	<u>0.4</u>
Total	100.0

Question: (addressed only to those who have cash sickness benefit insurance): Including yourself, how many members of your immediate family does this insurance cover?

Response:

One	55.2 per cent
Two	15.7
Three	9.7
Four	8.1
Five	2.1
Six	1.3
Seven and over	0.6
No information	2.9
Don't know	<u>4.4</u>
Total	100.0

COVERAGE BY HOSPITALIZATION INSURANCE

Question: Do you or does any member of your immediate family have insurance or belong to a hospital plan which pays the hospital for all or part of the hospital bills?

Response:

Yes	44.4 per cent
No	53.1
Don't know	<u>2.5</u>
Total	100.0

Question: (addressed only to those who have hospitalization insurance):
How much does this hospital insurance cost you or your family?

Response:

Under \$1.00 per month	9.6 per cent
\$1 - 1.99	21.6
\$2 - 2.99	26.2
\$3 - 4.99	5.5
\$5 and over	2.7
Combination with other insurance	1.2
No figure given	1.3
None	*
Don't know	30.5
No information	<u>1.3</u>
Total	100.0

* Less than 0.1 per cent.

Question: (addressed only to those who have hospitalization insurance):
If any part of this hospital insurance is paid for by an employer, how much does the employer pay?

Response:

Under \$1.00 per month	0.6 per cent
\$1 - 1.99 " "	0.3
\$2 - 2.99 " "	0.6
\$3 - 4.99 " "	0.3
\$5 and over " "	0.3
Combination with other insurance	0.0
No figure given; or, is paid, but don't know amount	13.3
None	74.0
Don't know	10.3
No information	0.3
Total	100.0

Question: (addressed only to those who have hospitalization insurance):
Including yourself, how many members of your immediate family does this hospital insurance cover?

Response:

One	22.1 per cent
Two	28.0
Three	18.7
Four	16.9
Five	6.6
Six	2.0
Seven and over	0.9
No information	1.9
Don't know	2.9
Total	100.0

INCIDENCE OF HOSPITAL TREATMENT

Question: During the last 12 months, have you or has any member of your immediate family received hospital treatment?

Response:

Yes	25.1 per cent
No	74.3
Don't know	0.5
No information	<u>*</u>
Total	100.0

* Less than 0.1 per cent.

COVERAGE BY MEDICAL CARE (PHYSICIAN) INSURANCE

Question: Do you or does any member of your immediate family have insurance which pays the doctor for all or part of the doctor bills?

Response:

Yes	9.8 per cent
No	87.8
Don't know	2.2
No information	<u>0.2</u>
Total	100.0

Question: (addressed only to those who have medical care insurance):
How much does this doctor insurance cost you or your family?

Response:

Under \$1.00 per month	7.4 per cent
\$1 - 1.99 " "	11.3
\$2 - 2.99 " "	13.0
\$3 - 4.99 " "	6.8
\$5 and over " "	8.0
Combination with other insurance	9.9
No figure given	3.1
None	0.3
Don't know	<u>40.2</u>
Total	100.0

Question: (addressed only to those who have medical care insurance):
If any part of this doctor insurance is paid for by an employer, how much does the employer pay?

Response:

Under \$1.00 per month	0.6 per cent
\$1 - 1.99 " "	0.0
\$2 - 2.99 " "	1.3
\$3 - 4.99 " "	0.0
\$5 and over " "	0.6
Combination with other Insurance	0.5
No figure given; or, is paid, but don't know amount	19.8
None	62.3
Don't know	12.9
No information	<u>2.0</u>
Total	100.0

Question: (addressed only to those who have medical care insurance):
Including yourself, how many members of your immediate family does this doctor insurance cover?

Response:

One	38.1 per cent
Two	21.9
Three	14.6
Four	14.4
Five	3.2
Six	1.4
Seven and over	1.1
No information	1.5
Don't know	<u>3.8</u>
Total	100.0

INCIDENCE OF PHYSICIAN TREATMENT

Question: During the last 12 months, have you or has any member of your immediate family had to see a doctor?

Response:

Yes	79.8 per cent
No	20.0
Don't know	0.1
No information	*
Total	100.0

* Less than 0.1 per cent.

MEDICAL INSURANCE vs. PAY-AS-YOU-GO

Question: Which one of these two ways to pay doctor and hospital expenses do you think is better?

(a) To pay doctor and hospital expenses as they come up,

or

(b) To make regular payments for insurance that will pay doctor and hospital expenses as they come up.

<u>Response (per cent):</u>	<u>Pay as expenses arise</u>	<u>Insurance</u>	<u>Don't know, and no information</u>
TOTAL	22.9	70.3	6.8
<u>Residential groups</u>			
Rural non-farm	29.3	64.9	5.8
Farm	28.5	62.8	8.7
City and village	22.2	71.2	6.6
<u>Sex groups</u>			
Male	21.8	72.5	5.7
Female	24.0	68.2	7.8
<u>Age groups</u>			
21-29 years	18.1	77.1	4.8
30-39 years	18.8	74.6	6.6
40 years & over	26.8	65.5	7.7
No information given	37.9	62.1	0.0
<u>Economic groups*</u>			
Under \$30 a month rent	29.0	62.5	8.5
\$30 - 39 a month rent	22.4	69.1	8.5
\$40 - 49 a month rent	23.2	72.0	4.8
\$50 - 74 a month rent	27.0	66.7	6.3
\$75 - 99 a month rent	25.7	71.2	3.1
\$100 and over a month rent	41.9	53.6	4.5
No information given	20.0	80.0	0.0
<u>Voting groups</u>			
Voted for Roosevelt, 1944	20.7	74.0	5.3
Voted for Dewey, 1944	30.5	60.6	8.9
Others	21.5	71.0	7.5

*Actual monthly rental, or equivalent in home ownership.

COMPULSORY OR VOLUNTARY INSURANCE?

Question: Which one of these two methods for doctor and hospital insurance would you choose?

- (a) A plan under which the amounts of your insurance payments would depend on the amount of your family's income - everybody would have to contribute to it - and it would be handled by the government,
- or
- (b) A plan under which the amounts of your insurance payments would be the same as for everybody - anyone could join or stay out - and it would be handled by a non-governmental group.

Response (per cent):

	<u>Compulsory</u>	<u>Voluntary</u>	<u>Don't know, and no information</u>
TOTAL	51.9	35.6	12.5
<u>Residential groups</u>			
Rural non-farm	24.0	56.1	19.9
Farm	42.5	42.5	15.0
City or village	52.2	35.4	12.4
<u>Sex groups</u>			
Male	54.0	35.5	10.5
Female	49.6	35.7	14.7
<u>Age groups</u>			
21-29 years	52.8	37.8	9.4
30-39 years	52.4	35.2	12.4
40 years & over	51.2	35.1	13.7
No information given	60.0	14.8	25.2
<u>Economic groups*</u>			
Under \$30 a month rent	41.2	41.3	17.5
\$30 - 39 a month rent	44.4	35.9	19.7
\$40 - 49 a month rent	56.7	32.7	10.6
\$50 - 74 a month rent	40.0	48.5	11.5
\$75 - 99 a month rent	49.4	37.2	13.4
\$100 and over a month rent	23.1	68.4	8.5
No information given	53.4	46.6	0.0
<u>Voting groups</u>			
Voted for Roosevelt, 1944	61.5	28.1	10.4
Voted for Dewey, 1944	31.8	52.5	15.7
Others	48.5	37.5	14.0

* Actual monthly rental, or equivalent in home ownership.

Question: (addressed only to those who favored compulsory insurance):
Which government do you think should handle it: the New York State Government or the Federal Government?

Response (per cent):

	<u>State</u>	<u>Federal</u>	<u>Don't know</u>	<u>Others</u>
TOTAL	32.6	48.4	18.5	0.5
<u>Residential groups</u>				
Rural non-farm	15.0	76.0	8.4	0.6
Farm	43.2	22.7	34.1	0.0
City or village	33.3	48.5	17.7	0.5
<u>Sex groups</u>				
Male	34.0	50.6	14.9	0.5
Female	30.9	46.1	22.5	0.5
<u>Age groups</u>				
21-29 years	31.2	54.8	14.0	0.0
30-39 years	35.1	44.8	19.8	0.3
40 years & over	31.7	47.5	19.9	0.9
No information given	65.6	25.2	9.2	0.0
<u>Economic groups*</u>				
Under \$30 a month rent	25.0	59.0	15.6	0.4
\$30 - 39 a month rent	31.9	54.1	13.8	0.2
\$40 - 49 a month rent	34.2	50.8	13.9	1.1
\$50 - 74 a month rent	33.9	52.4	13.3	0.4
\$75 - 99 a month rent	49.2	35.0	15.8	0.0
\$100 and over a month rent	24.1	75.9	0.0	0.0
No information given	50.0	50.0	0.0	0.0
<u>Voting groups</u>				
Voted for Roosevelt, 1944	32.3	50.9	16.0	0.8
Voted for Dewey, 1944	39.6	43.8	16.2	0.4
Others	30.9	45.5	23.4	0.2

*Actual monthly rental, or equivalent in home ownership.

Question: (addressed only to those who favored voluntary insurance)

Which of the following do you think should handle it:

Insurance companies
 Doctor groups
 Employers
 Unions
 Others

<u>Response (per cent):</u>	<u>Insurance companies</u>	<u>Doctor groups</u>	<u>Employers</u>	<u>Don't know and others</u>
TOTAL	59.9	14.6	7.2	18.3
<u>Residential groups</u>				
Rural non-farm	64.4	3.8	7.5	24.3
Farm	63.6	15.9	4.6	15.9
City and village	61.0	14.7	7.2	17.1
<u>Sex groups</u>				
Male	64.4	12.1	8.2	15.3
Female	55.3	17.4	6.2	21.1
<u>Age groups</u>				
21-29 years	57.2	23.1	4.6	15.1
30-39 years	59.2	12.3	7.8	20.7
40 years & over	62.8	11.1	8.2	17.9
No information given	18.5	37.9	0.0	43.6
<u>Economic groups*</u>				
Under \$30 a month rent	59.3	10.2	4.5	26.0
\$30 - 39 a month rent	65.7	12.2	1.9	20.2
\$40 - 49 a month rent	59.5	20.5	9.0	11.0
\$50 - 74 a month rent	64.3	16.0	9.3	10.4
\$75 - 99 a month rent	50.8	5.5	9.8	33.9
\$100 and over a month rent ..	74.4	15.1	7.9	2.6
No information given	58.4	41.6	0.0	0.0
<u>Voting groups</u>				
Voted for Roosevelt, 1944 ..	65.8	13.7	6.1	14.4
Voted for Dewey, 1944	55.2	14.9	9.5	20.4
Others	58.4	14.7	6.9	20.0

* Actual monthly rental, or equivalent in home ownership.

POPULATION TO BE COVERED

Question: If a doctor and hospital insurance plan is put into effect in this State, do you think it should cover everybody or just those people who work for business and industrial companies?

Response (per cent):

	<u>Every- body</u>	<u>Business and industrial</u>	<u>Don't know</u>	<u>Others</u>
TOTAL	85.4	6.5	8.0	0.1
<u>Residential groups</u>				
Rural non-farm	89.9	1.6	8.5	0.0
Farm	76.8	6.8	16.4	0.0
City and village	85.9	6.9	7.1	0.1
<u>Sex groups</u>				
Male	85.8	6.8	7.4	0.0
Female	85.0	6.3	8.7	0.0
<u>Age groups</u>				
21-29 years	90.6	5.0	4.3	0.1
30-39 years	85.3	6.9	7.8	0.0
40 years & over	83.0	7.1	9.8	**
No information given	100.0	0.0	0.0	0.0
<u>Economic groups*</u>				
Under \$30 a month rent	81.8	6.7	11.5	0.0
\$30 - 39 a month rent	85.4	6.4	8.0	0.2
\$40 - 49 a month rent	90.8	4.3	4.9	0.0
\$50 - 74 a month rent	82.0	9.9	8.1	0.0
\$75 - 99 a month rent	85.6	5.0	9.4	0.0
\$100 and over a month rent	80.3	9.3	10.4	0.0
No information given	80.0	0.0	20.0	0.0
<u>Voting groups</u>				
Voted for Roosevelt, 1944	89.1	5.1	5.8	0.0
Voted for Dewey, 1944	82.0	8.5	9.4	0.1
Others	83.0	7.5	9.5	0.0

* Actual monthly rental, or equivalent in home ownership.

** Less than 0.1 per cent.

EMPLOYER CONTRIBUTION

Question: If a doctor and hospital insurance plan is put into effect in this State:

- (a) Should it cover just those people who work for business and industrial companies, with one-half of their payments being made by the workers themselves and one-half by their employers?

or

- (b) Should it cover everybody, with each person making all his payments for it?

<u>Response (per cent):</u>	<u>Employer contribution</u>	<u>Individual, only</u>	<u>Don't know</u>	<u>Others</u>
TOTAL	33.7	52.8	13.1	0.4
<u>Residential groups</u>				
Rural non-farm	22.0	64.1	13.9	0.0
Farm	14.9	69.1	15.5	0.5
City and village	35.6	51.5	12.5	0.4
<u>Sex groups</u>				
Male	34.4	55.2	9.8	0.6
Female	33.1	50.3	16.5	0.1
<u>Age groups</u>				
21-29 years	34.3	55.9	9.1	0.7
30-39 years	34.7	52.5	12.3	0.5
40 years & over	33.4	51.4	15.0	0.2
No information given	0.0	74.8	25.2	0.0
<u>Economic groups*</u>				
Under \$30 a month rent	26.5	59.9	13.5	0.1
\$30 - 39 a month rent	29.5	55.2	14.9	0.4
\$40 - 49 a month rent	39.5	52.6	7.2	0.7
\$50 - 74 a month rent	33.2	54.3	12.5	0.0
\$75-99 a month rent	28.0	60.7	11.3	0.0
\$100 and over a month rent	17.5	71.6	10.9	0.0
No information given	16.6	63.4	20.0	0.0
<u>Voting groups</u>				
Voted for Roosevelt, 1944	37.4	51.3	10.8	0.5
Voted for Dewey, 1944	25.7	61.3	12.9	0.1
Others	32.5	51.6	15.4	0.5

* Actual monthly rental, or equivalent in home ownership.

CASH SICKNESS BENEFITS

Question: Do you think the plan should also pay to employed workers about one-half of their usual earnings during the time they are not able to work because of illness or an accident - and for this the insurance payments from employed workers would be increased, according to the amount of their earnings?

Response (per cent):

	<u>Yes</u>	<u>No</u>	<u>Don't know</u>	<u>Others</u>
TOTAL	63.1	17.8	18.7	0.4
<u>Residential groups</u>				
Rural non-farm	67.8	13.6	18.6	0.0
Farm	50.3	24.6	25.1	0.0
City and village	63.3	18.1	18.1	0.5
<u>Sex groups</u>				
Male	63.7	18.3	17.6	0.4
Female	62.7	17.2	19.7	0.4
<u>Age groups</u>				
21-29 years	70.4	14.9	14.6	0.1
30-39 years	60.8	20.7	18.0	0.5
40 years & over	61.6	17.6	20.5	0.3
No information given	34.7	12.6	40.1	12.6
<u>Economic groups*</u>				
Under \$30 a month rent	69.3	9.3	20.5	0.9
\$30 - 39 a month rent	59.8	17.2	22.9	0.1
\$40 - 49 a month rent	59.3	23.1	17.6	0.0
\$50 - 74 a month rent	54.0	27.6	18.4	0.0
\$75 - 99 a month rent	57.1	37.2	5.7	0.0
\$100 and over a month rent	47.4	40.4	10.9	1.3
No information given	70.0	0.0	30.0	0.0
<u>Voting groups</u>				
Voted for Roosevelt, 1944	70.1	13.8	15.8	0.3
Voted for Dewey, 1944	59.6	22.8	17.5	0.1
Others	59.2	18.5	21.7	0.6

* Actual monthly rental, or equivalent in home ownership.



W 275 AN6 qC7m 1946

28130870R



NLM 05114703 4

NATIONAL LIBRARY OF MEDICINE